Member Handbook
July 2003

Commonwealth of Virginia

Administered by the
Department of Human Resource Management

T20338 (5/03)

COVA Care Member Handbook

This member booklet fully explains your health care benefits and how you can maximize them. Treat it as you treat the owner's manual for your car - store it in a convenient place and refer to it whenever you have questions about your health care coverage.

Important contacts

Anthem Member Services

804-355-8506 in Richmond
800-552-2682 from outside Richmond
(Message Center available 24 hours a day)

Hours of Operation:
Monday-Friday 8:00 a.m. to 6:00 p.m. ET
Saturday 9:00 a.m. to 1:00 p.m. ET

Hospital Admission Review and Medical Necessity Review
804-359-7277 in Richmond
800-242-7277 from outside Richmond
(available 24 hours a day)

Magellan Behavioral Health

800-775-5138 (available 24 hours a day)

Visit Anthem online at www.anthem.com
Choose Virginia under Members & Consumers. From the home page, select the Commonwealth of Virginia and The Local Choice Member's link.

Visit Magellan online at www.magellanassist.com

Visit the Department of Human Resource Management online at www.dhrm.state.va.us

☞ **Helpful tip:** Look for these icons to identify which services are considered inpatient and which are outpatient or to identify individual and family deductible and out-of-pocket expense limits.


Inpatient


Outpatient


Individual


Family

Key words

There are a few key words you will see repeated throughout this booklet. We've highlighted them here to make the booklet easier to understand. In addition, we have included a **Definitions** section on page 69 that lists the various words referenced. A defined word will be italicized each time it is used.

Covered persons

You and enrolled eligible dependents.

Outpatient

When you receive care in a hospital outpatient department, emergency room, professional provider's office, or your home.

Inpatient

When you are a bed patient in the hospital.

Your health plan

Your employer's health care plan through which benefits described in this booklet are available.

You

The enrolled member.

Copayment

The fixed dollar amount you pay for some covered services.

Coinsurance

The percentage of the allowable charge you pay for some covered services.

Deductible

The fixed dollar amount of covered services you pay in a calendar year before your health plan will pay for certain remaining covered services during that calendar year.

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COVA Care

Notification of Correction to Your Member Handbook
Effective July 1, 2003

1) When you are covered by more than one health plan – Page 46

The final paragraph on page 46 of your COVA Care Member Handbook describes how the amount payable for secondary coverage under Coordination of Benefits (COB) is calculated. The text below clarifies this process and replaces the final paragraph as follows:

When *your health plan* (COVA Care) is the primary coverage, it pays first. When *your health plan* is the secondary coverage, it pays second as follows:

- *We* calculate the amount *your health plan* would have paid if it had been the primary coverage, and coordinate this amount with the primary plan's payment. The combination of the two will not exceed the amount *your health plan* would have paid if it had been your primary coverage.
- Some plans provide services rather than making a payment (i.e., a group model HMO). When such a plan is the primary coverage, *your health plan* will assign a reasonable cash value for the services and that will be considered the primary plan's payment. *Your health plan* will then coordinate with the primary plan based on that value.
- In no event will *your health plan* pay more in benefits as secondary coverage than it would have paid as primary coverage.

Example: Specialist Office Visit

The primary health plan (ABC Health Care Plan) has a $50 copayment and then pays the remainder of the bill. The secondary health plan (*your health plan*) has a $35 copayment.

Amount Billed	$100
What y*our health plan* would have paid if primary ($100 - $35 copayment = $65)	$ 65
Primary plan's payment ($100 - $50 copayment = $50)	$ 50
Your health plan's secondary payment ($65 - $50 = $15)	$ 15

COVA Care Basic Plan Summary of Benefits

This chart is an overview of your benefits for covered services under the basic plan. They are listed in detail beginning on page 15. A list of services that are not covered begins on page 33. Optional benefits, which may be purchased for additional cost, are shown beginning on page 82.

What will I pay?

This chart shows what you pay for deductibles and out-of-pocket expenses for covered services in one year of coverage, along with your copayment or coinsurance amounts.

Most services are not subject to a lifetime maximum amount. However, a few *other covered services* do have a $1,500,000 lifetime maximum for each covered person. Should you meet your lifetime maximum amount, *your health plan* will annually reinstate the amount that it paid for *other covered services* during the previous year, not to exceed $2,000. *Other covered services* include ambulance travel, medical equipment, etc. They are defined on page 71. Please also see the **Claims and payments** section on page 42 for more information on the lifetime maximum.

Your coverage also includes a separate $25,000 lifetime maximum for each covered person for the identification of a suitable donor for organ and tissue transplant services. See page 29 for organ and tissue transplant coverage.

	In-network		Detail Page number
			
Calendar year deductible (applies as indicated)	$200	$400	42
Your annual out-of-pocket expense limit	$1,500	$3,000	42

	In-network*			Detail Page number
	Copayment	Coinsurance		
Ambulance Travel No calendar year limit	$0	20%	after deductible	15
Dental services (non-routine)	$0	20%	after deductible	17
Diabetic equipment	$0	20%	after deductible	17
Diabetic education	$0	0%		17
Diagnostic tests and x-rays for specific conditions or diseases at a doctor's office, emergency room, or outpatient hospital department	$0	10%	after deductible	18
Dialysis treatments				
Facility	$0	0%		18
Doctor's Office	$0	0%		18
Doctor visits on an outpatient basis				
Primary Care Physicians	$25	0%		18
Specialty Care Providers	$35	0%		18
Early intervention services	Copayment/coinsurance determined by service received.			18

*** Except in an emergency, you do not have Out-of-network benefits unless you purchase the out-of-network option. See Optional benefits section.**

	In-network*			Detail
	Copayment	Coinsurance		Page number
Emergency room visits				
Facility services	$100 *per visit* (waived if admitted)	0%		19
Professional provider services				
Primary Care Physicians	$25	0%		19
Specialty Care Providers	$35	0%		19
Diagnostic tests, shots, x-rays	$0	10%	after deductible	18
Home care services				
Home health services	$0	0%		19
90 - visit calendar year limit				
Home infusion services	$0	0%		19
Home private duty nurse's services	$0	20%	after deductible	20
Hospice care services	$0	0%		20
Hospital services				
Inpatient treatment				
Facility services	$300 *per stay*	0%		20
Professional provider services				
Primary Care Physicians	$0	0%		20
Specialty Care Providers	$0	0%		20
Outpatient treatment				
Facility services	$100	0%		20
Professional provider services				
Primary Care Physicians	$25	0%		20
Specialty Care Providers	$35	0%		20
Diagnostic tests, shots, x-rays	$0	10%	after deductible	18
Maternity				
Professional provider services				
Prenatal and postnatal follow-up care				
Primary Care Physicians	$25	0%		21
Specialty Care Providers	$35	0%		21
Delivery				
Primary Care Physicians	$0	0%		21
Specialty Care Providers	$0	0%		21
Hospital services for delivery delivery room, anesthesia, nursing care for newborn	$300 *per stay*	0%		21
Diagnostic tests	$0	10%	after deductible	18
Medical equipment, appliances, and supplies	$0	20%	after deductible	22

*** Except in an emergency, you do not have Out-of-network benefits unless you purchase the out-of-network option. See Optional benefits section.**

	In-network*			Detail
	Copayment	Coinsurance		Page number
Mental health and substance abuse treatment				23
Administered by Magellan Behavioral Health				
Inpatient treatment				23
Facility services	$300 *per stay*	0%		23
Professional provider services	$0	0%		23
Partial day program	$300 *per stay*	0%		23
Outpatient treatment				
Facility services	$100	0%		23
Specialty Care Providers	$35	0%		23
Employee assistance program	$0	0%		23
Four visits per incident				
Shots (allergy and therapeutic injections) at a doctor's office, emergency room or outpatient hospital department	$0	10%	after deductible	27
Skilled nursing facility stays				27
180-day per stay limit				
Facility services	$0 *per stay*	0%		27
Professional provider services	$0	0%		27
Spinal manipulations and other manual medical interventions				
$500 calendar year limit				
Primary Care Physicians	$25	0%		27
Specialty Care Providers	$35	0%		27
Surgery				28
Inpatient				
Facility services	$300 *per stay*	0%		28
Professional provider services				
Primary Care Physicians	$0	0%		28
Specialty Care Providers	$0	0%		28
Outpatient				
Facility services	$100 *per visit*	0%		28
Professional provider services				
Primary Care Physicians	$25	0%		28
Specialty Care Providers	$35	0%		28
Diagnostic tests, shots, x-rays	$0	10%	after deductible	18
Therapy - outpatient services ****				
Cardiac rehabilitation therapy				
Hospital services	$0	0%		30
Professional provider services	$0	0%		30

*** Except in an emergency, you do not have Out-of-network benefits unless you purchase the out-of-network option. See Optional benefits section.**

**** See Hospital services for payment amounts for inpatient therapy.

	In-network*			Detail
	Copayment	Coinsurance		Page number
Chemotherapy				
Hospital services	$0	0%		30
Professional provider services	$0	0%		30
Infusion Therapy				
Hospital services	$0	0%		30
Professional provider services	$0	0%		30
Occupational therapy visits				
Hospital services	$35	0%		30
Professional provider services				
Primary Care Physicians	$25	0%		30
Specialty Care Providers	$35	0%		30
Physical therapy visits				
Hospital services	$35	0%		30
Professional provider services				
Primary Care Physicians	$25	0%		30
Specialty Care Providers	$35	0%		30
Radiation therapy				
Hospital services	$0	0%		30
Professional provider services	$0	0%		30
Respiratory therapy				
Hospital services	$0	0%		31
Professional provider services	$0	0%		31
Speech therapy visits				
Hospital services	$35	0%		31
Professional provider services				
Primary Care Physicians	$25	0%		31
Specialty Care Providers	$35	0%		31
Vision correction after surgery or accident	$0	20%	after deductible	31
Wellness services				
Well child				
Office visits at specified intervals through age 6				
Primary Care Physicians	$25	0%		31
Specialty Care Providers	$35	0%		31
Immunizations				
Primary Care Physicians	$0	0%		31
Specialty Care Providers	$0	0%		31
Screening tests	$0	10%	no deductible	31
Routine wellness and preventive care				
Routine wellness (age 7 and older)				
Annual check-up visit				
Primary Care Physicians	$25	0%		32
Specialty Care Providers	$35	0%		32
Immunizations**				
Primary Care Physicians	$0	10%	no deductible	32
Specialty Care Providers	$0	10%	no deductible	32
Lab and x-ray services**	$0	10%	no deductible	32

**Your health plan pays 90% coinsurance up to $200 per calendar year for routine immunizations, lab and x-ray services.

*** Except in an emergency, you do not have Out-of-network benefits unless you purchase the out-of-network option. See Optional benefits section.**

	In-network*			Detail
	Copayment	Coinsurance		Page number
Colorectal cancer screenings	$0	10%	no deductible	32
Preventive care				
Annual gynecological exam				
Primary Care Physicians	$25	0%		32
Specialty Care Providers	$35	0%		32
Annual Pap test	$0	10%	no deductible	32
Annual mammography screening	$0	10%	no deductible	32
Prostate exams (digital rectal exams)				
Primary Care Physicians	$25	0%		32
Specialty Care Providers	$35	0%		32
Prostate specific antigen test	$0	10%	no deductible	32

	Copayment	Detail Page number
Prescription drugs		24
Retail pharmacy		24
covered drugs per 34-day supply		
First tier	$15	24
Second tier	$20	24
Third tier	$35	24
Medco Health Home Delivery Services		26
covered drugs for up to a 90-day supply		
First tier	$30	26
Second tier	$40	26
Third tier	$70	26

Dental services (routine)

Calendar year deductible	$0
The most Anthem will pay per calendar year	$1200

	Copayment	Coinsurance	Detail Page number
Diagnostic and preventive services	$0	0%	15
Primary services (no deductible)	$0	20%	16

How your health plan works

Your health plan provides a wide range of health care services within a special network of health care *providers* and *facilities. You* will receive benefits based on where *you* receive health care services and the limits stated in the **Summary of benefits** (see page 1) and related exclusions. *Your health plan* is a self-funded benefits plan sponsored by the Commonwealth of Virginia, which has entered into separate administrative services contracts with Anthem Blue Cross and Blue Shield for covered medical services and Magellan Behavioral Health for covered mental illness and substance abuse treatment services.

Carry your ID card

Your ID card identifies *you* as a *covered person* and contains important health care coverage information. When *you* show your ID card to your doctor, hospital, pharmacist, or other health care *provider,* they will file your claims for *you* in most cases. Carrying your card at all times will ensure *you* always have this coverage information with *you* when *you* need it.

In an emergency or if specialty care is not reasonably available in the network

In an *emergency,* go to the nearest appropriate *provider* or medical *facility.* If the *provider* or *facility* is not in the network, *you* or your network physician can call Anthem to have medical services authorized for coverage, or Magellan Behavioral Health to have mental health services authorized for coverage. Non-emergency care received from *providers* and *facilities* not in the network is not covered.

If specialty care is required and it is not available from a *provider* within the network, your network *provider* can call Anthem or Magellan in advance of your receiving care to request authorization for coverage.

Anthem - how your medical plan works

Covered medical providers and facilities

Your health plan covers certain care from *providers* and *facilities.* To ensure benefits, *providers* and *facilities* must be licensed in the state where they operate to perform the service *you* receive. The service also must be covered by *your health plan.* Certain services are covered by the plan and rendered by other covered medical suppliers, such as suppliers of *durable medical equipment,* private duty nursing services, *prescription drugs,* ambulance services, etc.

A *provider* may delegate to his employee the responsibility for performing a covered service. *Your health plan* will cover this care if it is determined that a bona fide employer-employee relationship exists, based on information given by the *provider.* Under these circumstances:

- both the *provider* and the delegated employee must be licensed/certified to render the service;

- the service must be performed under the direct supervision of the *provider* since the *provider* is primarily responsible for the patient's care; and
- the *provider* who is directly supervising the service must bill for the service.

Because the service of the delegated employee is a substitute for the *provider's* service, *your health plan* will not pay a supervisory or other fee for the same service performed by both the *provider* and his delegated employee.

Primary care physicians and specialty care providers

Your health plan covers care provided by *primary care physicians* and *specialty care providers.* To see a *primary care physician,* simply visit any network physician who is a general or family practitioner, internist or pediatrician. *Your health plan* also covers care provided by any *specialty care provider you* choose. Referrals are never needed to visit any *specialty care provider.*

Your medical provider networks

Anthem network

Your plan covers medical care provided by hospitals, primary care physicians and specialists. To see a primary care physician, simply visit an Anthem network physician who is a general or family practitioner, internist or pediatrician. Your plan also covers care provided by any other specialist in the Anthem network. Referrals are never needed to visit a network specialist. However, higher copayments apply for specialist visits.

You will find the most current directory of Anthem network providers on the Web at **www.anthem.com** under Members & Consumers, Virginia. You may also contact Anthem Member Services at **800-552-2682** or see your agency *benefits administrator* for a printed directory.

☞ **Helpful tip:** Remember, you have coverage from network providers only, unless you purchased the Out-of-network option.

BlueCard® PPO for Care within the United States

If you need medical care outside the Anthem network and within the United States, you will have access to care from a BlueCard PPO provider. Through the BlueCard PPO program, your Anthem Blue Cross and Blue Shield ID card is accepted by physicians and hospitals throughout the country who participate with another Blue Cross Blue Shield company. These providers accept your copayment or coinsurance at the time of service instead of requiring full payment. They file claims directly to their local Blue Cross Blue Shield company for you, and have agreed to accept the allowable charge established by the local company as payment in full.

To locate a BlueCard PPO physician or hospital call **800-810-BLUE (2583).** Or use the BlueCard Doctor and Hospital Finder on the Web at **www.bcbs.com.** Providers can also tell you if they participate in BlueCard PPO when you call to make an appointment.

Simply present your Anthem ID card when you receive care. The PPO suitcase logo at the top of your card tells the physician or hospital that your COVA Care plan includes the BlueCard PPO program.

How Charges Are Calculated for BlueCard PPO Services

The amount used to calculate your payment responsibility for a covered service will usually be the lower of:

- the billed charge for the covered service; or
- the negotiated price passed on to Anthem through the BlueCard program.

Often, this "negotiated price" will consist of a simple discounted price. It can also be an estimated or average price allowed by the BlueCard program and the terms of your health care plan. An estimated price takes into account special arrangements with a provider or provider group that include settlements, withholds, non-claims transactions (such as provider advances) and other types of variable payments. An average price is based on a discount that takes into account these same special arrangements. Of the two, estimated prices are usually closer to the actual prices.

Negotiated prices may be adjusted going forward to correct for over- or under-estimation of past prices. However, the amount you pay is considered a final price.

Laws in a small number of states may require the local Blue Cross and/or Blue Shield plan to use another method for calculating the charge, or add a surcharge to your liability calculation. In these states, Anthem Blue Cross and Blue Shield would calculate your liability according to the applicable state law in effect when you received care.

BlueCard® Worldwide for Care outside the United States

If you live or travel outside the United States, the BlueCard Worldwide program assists you to obtain inpatient and outpatient hospital care and physician services.

Follow these steps before you travel:

1. Obtain a list of BlueCard Worldwide hospitals located where you will be traveling or staying. You may obtain this information on the Web at **www.bcbs.com .** Select Healthcare Anywhere on the home page. Or you may call **800-810-BLUE (2583)** for assistance.
2. Be sure to carry your Anthem medical ID card with you and present it when you need inpatient care.

If you need care once you arrive at your destination, follow these simple steps:

Inpatient hospital care (non-emergency):

1. Call the Service Center at **800-810-BLUE** or call collect to **804-673-1177.** A BlueCard Worldwide Service Center representative will accept the charges and will facilitate hospitalization at a BlueCard

Worldwide hospital. It is important that you call the Service Center in order to obtain cash-less access for inpatient care. The hospital will submit your claim for you. The Service Center is staffed with multilingual representatives and is available 24 hours a day, seven days a week.

2. Call Anthem at **800-242-7277** for hospital admission review.

Inpatient hospital care (emergency):

Bypass the above steps. Go to the nearest hospital. Call the Service Center at **800-810-BLUE** or call collect to **804-673-1177** if you are admitted to arrange cash-less access (available in most cases). A BlueCard Worldwide Service Center representative will assist you. A family member or friend can make this call for you.

Outpatient hospital care/physicians services:

1. Call **800-810-BLUE** or call collect to **804-673-1177.** A BlueCard Worldwide Service Center representative will accept the charges and will make an appointment with a doctor for you, or will direct you to a hospital.
2. You will need to pay for your care and then submit a claim using the International Claim Form to the BlueCard Worldwide Service Center (address is on the claim form). Contact the Service Center for the form, or you may download the form on the Web at **www.bcbs.com .** Select Healthcare Anywhere on the home page.

How to find a provider in the Anthem network

There are several ways *you* can find out if a *provider* or *facility* is in your network:

- The directory may be accessed online at **www.anthem.com.** Choose Virginia, then the Commonwealth of Virginia and The Local Choice Member's link.
- Refer to *your health plan's* printed directory.
- Check with your doctor or health care *facility.*
- Call Anthem Member Services.

Allowable charge

Providers or facilities	Allowable charge
providers within your network	the network allowance or *provider's* charge, whichever is less
network and participating *facilities*	the negotiated allowance or the *facility's* charge, whichever is less
non-provider, non-*facility* service (e.g., ambulance, home private duty nurses, etc.)	the amount Anthem determines to be reasonable for the services rendered

In the *allowable charge* chart, the allowance for covered services and the reasonable charge for covered services are determined by Anthem and other Blue Cross Blue Shield companies at their sole discretion.

Another Blue Cross Blue Shield company may pay a claim on our behalf to a *facility* that participates in one of its networks. When this occurs, the *allowable charge* will be the lower of the billed charges of the *facility* or the negotiated price that the Blue Cross Blue Shield company passes on to us. The negotiated price may be a simple discount of billed charges, an estimated final price that reflects future settlement with the *facility,* or an average expected savings from the *facility* or network. The estimated or average price may have been adjusted to correct for over- or under-estimation of past prices or non-claim transaction costs.

If Anthem's negotiated compensation cannot be determined at the time the claim for the covered service is processed, Anthem will use the value of the last known negotiated compensation derived from its most recent settlement with the *facility.*

☞ **Helpful tip:** Under COVA Care basic, you have no out-of-network coverage except in an *emergency.* If you purchased the Out-of-network option, you have coverage outside the network, but the *provider* may bill you for amounts above the *allowable charge.*

Allowable charge for surgical services

Your health plan will not pay separately for pre- and post-operative services. If more than one surgical procedure is performed during the same operation, we will calculate the *allowable charge* for all of the services combined by adding:

- the *allowable charge* for the service with the highest *allowable charge;* plus
- 50% of the *allowable charge* for each of the next three surgical services if they had been performed separately.

This is the most *your health plan* will pay during a single operation, unless extraordinary circumstances exist.

Assistant at surgery

Services of a physician who actively assists the operating surgeon to perform a covered surgical service are covered services. However, when two or more surgeons provide a covered surgical service that could have been performed by one surgeon, the *allowable charge* will not be more than that available to one surgeon.

Anesthesia

When surgical services require anesthesia, anesthesia services rendered by a second physician are covered services. However, when the physician performs both the surgical service and the anesthesia service, the *allowable charge* for the anesthesia services will be 50% of what it would have been if a second physician had performed the anesthesia service.

Hospital Admission Review

All hospital *stays,* skilled nursing home *stays,* or treatment in partial day programs should be approved before each admission. If *you* are admitted to the hospital as a result of an *emergency,* within 48 hours of admission your hospital *stay* should be reviewed by Anthem for medical services or by Magellan Behavioral Health for mental health or substance abuse services. The *emergency* room doctor, a relative, or a friend can call for Hospital Admission Review. Network *providers* and *facilities* handle Hospital Admission Review for *you.* If *you* receive care from a network *facility* or *provider* while outside of Virginia or overseas, *you* must initiate the Hospital Admission Review process. If *you* fail to obtain approval for an *inpatient stay,* and the *stay* is later determined not to be *medically necessary, you* may have to pay the entire hospital bill in addition to any charges for services provided while *you* were an *inpatient.* Strict adherence to this procedure may not be required for services that arise over the weekend.

Before *you* are admitted to the hospital for medical care or surgery, *you,* your doctor, or someone *you* authorize must call **804-359-7277** in Richmond or **800-242-7277** from outside of Richmond. *You* should have the following information available:

- your Anthem Blue Cross and Blue Shield identification number (shown on your ID card);
- your doctor's name and phone number;
- the date *you* plan to enter the hospital and length of *stay;* and
- the reason for hospitalization.

Your health plan will respond to a request for hospital admission within 2 working days after receiving all of the medical information needed to process the request, but not to exceed 15 days from the receipt of the request. *We* may extend this period for another 15 days if *we* determine it to be necessary because of matters beyond *our* control. In the event that this extension is necessary, *you* will be notified prior to the expiration of the initial 15-day period.

In cases where the hospital admission is an urgent care claim, a coverage decision will be completed within 24 hours. Your physician will be notified verbally of the coverage decision within this time frame.

Once a coverage decision has been made regarding your hospital admission, *you* will receive written notification of the coverage decision. In the event of an adverse benefit determination, the written notification will include the following:

- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of *your health plan's* appeal procedures and applicable time limits; and
- in the case of an urgent care claim, a description of the expedited review process applicable to such claims.

If all or part of a hospital admission was not covered, *you* have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that *your health plan* relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, *you* are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to your medical condition.

Hospital admissions for covered radical or modified radical mastectomy for the treatment of breast cancer shall be approved for a period of no less than 48 hours. Hospital admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours. Hospital admissions for a covered laparoscopy-assisted vaginal hysterectomy shall be approved for a period of no less than 23 hours. Hospital admissions for a covered vaginal hysterectomy shall be approved for a period of no less than 48 hours.

The length of stay for maternity admissions is determined according to the Newborn's and Mother's Health Protection Act. This federal law allows for 48 hours for vaginal delivery or 96 hours for caesarian section. Admissions for maternity care do not, initially, require Hospital Admission Review. However, if complications develop and additional days are necessary, Hospital Admission Review is required. *We* request that your doctor contact Anthem to establish eligibility and waiting periods.

Admissions to hospitals located outside of Virginia

If *you* are admitted to a hospital outside of Virginia, *you* or someone on your behalf must initiate the Hospital Admission Review process. This applies in all cases, whether *you* live, work, or travel outside of Virginia. If approval is not obtained for an *inpatient stay* and the *stay* is later determined by Anthem not to be *medically necessary, you* may have to pay the entire hospital bill in addition to any charges for services provided while *you* were an *inpatient.*

Medical necessity review

In addition to the Hospital Admission Review process, *your health plan* requires medical necessity review of selected services. Some examples of these services include:

- elective ambulance services;
- non-routine dental services;
- diabetic education;
- home care services (except home infusion therapy);

- medical equipment, devices, appliance and supplies;
- spinal manipulations in conjunction with physical therapy;
- morbid obesity treatment;
- non-routine oral surgery;
- organ and tissue transplants; and
- cardiac rehabilitation.

Your health plan recommends completing the medical necessity review process in advance of actually receiving services so that *you* will know beforehand whether or not the services meet the medical necessity criteria. Services that do not meet the medical necessity criteria are not covered. If *you* do not complete the medical necessity review process prior to receiving services, the review will be completed at the time the claim is processed.

Individual case management

In addition to the covered services listed in this booklet, *your health plan* may elect to offer benefits for an approved alternate treatment plan for a patient who would otherwise require more expensive covered services. This includes, but is not limited to, long term *inpatient* care. *Your health plan* will provide alternate benefits at its sole discretion. It will do so only when and for so long as it decides that the services are *medically necessary* and cost effective. The total benefits paid for such services may not exceed the total that would otherwise be paid without alternate benefits. If *your health plan* elects to provide alternate benefits for a *covered person* in one instance, it will not be required to provide the same or similar benefits for any *covered person* in any other instance. Also, this will not be construed as a waiver of *your health plan's* right to enforce the terms of *your health plan* in the future in strict accordance with its express terms.

Also, from time to time *your health plan* may offer a *covered person* and/or their *provider* or *facility* information and resources related to disease management and wellness initiatives. These services may be in conjunction with the *covered person's* medical condition or with therapies that the *covered person* receives, and may or may not result in the provision of alternative benefits as described in the preceding paragraph.

If you have a pre-existing condition

Pre-existing conditions are covered under *your health plan. You* do not have to satisfy a waiting period before services for pre-existing conditions are covered.

Creditable coverage

In the event that *you* leave this health plan and go to a health plan that includes a *pre-existing condition* waiting period, *you* may be eligible for creditable coverage. The following list is considered creditable coverage and your new health plan may reduce the *pre-existing condition* waiting period by the amount of time, if any, *you* were covered by the following similar plans:

- Medicare, Medicaid, Tricare, a medical care program of the Indian Health Service Program or a tribal organization, a health benefit plan under the Peace Corps Act, a state health benefits risk pool, or any other similar publicly-sponsored program;
- a group health benefit plan;
- a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et. Seq.);
- a public health plan (as defined in federal regulations);
- your current employer's eligibility waiting period;
- health insurance coverage consisting of benefits for medical care issued by an insurer, a health maintenance organization, a health service plan, or a fraternal benefit society; or
- individual health insurance coverage.

If you should leave the COVA Care plan, your *benefits administrator* will provide you with proof of prior coverage (certificate of coverage) for your new health plan if needed.

Magellan - how your mental health and substance abuse plan works

Magellan Behavioral Health administers *your health plan's* mental health and substance abuse treatment benefits. It is recommended that all services be preauthorized by calling Magellan at **800-775-5138.** A broad range of mental health and substance abuse services are available for various conditions. However, if services are not considered *medically necessary* to treat the condition, Magellan will not reimburse for those services.

Your mental health providers

When you receive care from a *provider* to whom you have been referred by Magellan, the *provider* works with a Magellan Care Manager to ensure that the services you receive are covered under *your health plan.* When you self-refer to a *provider,* you are responsible for making sure that the services you receive are *medically necessary* for your condition. Contact Magellan at **800-775-5138** for *preauthorization* on the specific services that will be covered in your situation.

How to find a mental health provider in the Magellan network

Contact Magellan at **800-775-5138.** A representative will assist you in determining the most appropriate type of *provider* for your situation and will assist with preauthorizing your care.

What is covered

Your health plan covers only those services that are *medically necessary.* Just because the service is prescribed by a *provider* does not mean the service is *medically necessary.* In addition, *your health plan* requires that services be safely performed in the least costly *setting.*

See the **Summary of benefits** (page 1) for payment levels and limits for the covered services. For details of the specific coverage provided as well as what is not covered, use the page number references on the summary. All of the following services, except as noted, must be rendered by covered *facilities* or *providers.*

Ambulance travel

Your health plan covers professional ambulance services to or from the nearest *facility* or *provider* adequate to treat your condition. Ambulance services billed through the *facility* are covered the same as all other *facility* services. Air ambulance services are also covered when preauthorized or in cases of threatened loss of life. In determining whether any ambulance services will be preauthorized, *we* will take into account whether appropriate, cost-effective care is being provided at the facility where the *covered person* is located.

Dental services

Your health plan covers the following dental services. In order to receive the highest level of benefits, *you* should receive dental care from Anthem contracting dentists. A contracting dentist is a dentist who, at the time of rendering professional services to *you,* is listed as contracting with Anthem Blue Cross and Blue Shield. Contracting dentists will file claims for *you* and agree to accept Anthem's *allowable charge* as payment in full. *You* are only responsible for applicable deductibles, copayments and coinsurance.

If you receive services from Anthem contracting dentists, you will not be subject to any expenses above the allowable charge. There are two ways that *you* can find out if a dentist is contracting:

- Call Anthem's Member Services.
- Check with your dentist.

Diagnostic and preventive services (routine)

Your health plan provides coverage for *you* to see your dentist twice a year for a checkup. This allows your dentist to identify any possible problems and to try and prevent cavities and serious dental problems. Covered services include:

- two routine oral evaluations per calendar year;
- two dental prophylaxes (cleanings) per calendar year, including scaling and polishing of teeth;
- dental x-rays (except x-rays needed to fit braces);
- space maintainers used to keep teeth from moving into space left when deciduous teeth are pulled;

- two tests to see if a tooth is still alive (pulp vitality tests) per calendar year;
- care for a toothache (palliative emergency care);
- two sets of bitewing x-rays (two or more films) per calendar year;
- one complete full mouth x-ray series or a panorex every 36 months;
- two topical fluoride applications per calendar year only to *covered persons* under age 19;
- dental pit/fissure sealants to the unrestored occlusal surface of the first and second permanent molars. Dental pit/fissure sealants are available only to *covered persons* under age 19;
- diagnostic casts;
- occlusal adjustments, bite planes or splints for temporomandibular joint disorders,; and
- occlusal night guards for demonstrated tooth wear due to bruxism.

Primary services (routine)

After your dentist has examined your teeth, *you* may need additional dental work. *Your health plan* includes coverage for the following:

- fillings (amalgam or tooth-colored materials);
- pin retention;
- pulling teeth (either a simple extraction or surgical removal, except surgical removal of impacted teeth which is covered under oral surgery);
- root canal therapy (endodontics);
- care for cysts, tumors or abscesses in the mouth (excision, drainage or removal);
- repair of broken removable dentures;
- making the gum ridges ready for false teeth;
- re-cementing existing crowns, inlays and bridges;
- treating a fracture of the jaw;
- removing infected parts of the gum and replacing them with healthy tissue (gingivectomy and gingivoplasty);
- scaling and root planing of the gum;
- stainless steel crowns;
- sedative fillings;
- therapeutic pulpotomy for primary "baby" teeth only;
- periodontal evaluations;
- an operation on the lining of the gum (mucogingivoplastic surgery);
- an operation to remove diseased portions of bone around the teeth (osseous surgery);
- soft tissue grafts;
- guided tissue regeneration;
- general anesthesia in connection with a covered dental service;
- crown lengthening;
- frenectomies;
- hemisection and root amputations;
- apicoectomies;
- periodontal maintenance therapy; and
- trips by the dentist to your home if *you* need any of the services *you* see listed here.

Dental services (non-routine)

Your health plan also provides coverage for the following:

- medically necessary dental services resulting from an accidental injury while covered under the plan if a plan of treatment from the dentist or oral surgeon is submitted to Anthem within 60 days of the date of the injury and subsequently approved;
- medically necessary dental services when required to diagnose or treat an accidental injury to the teeth if the accident occurs while you are covered under the plan. These services and appliances are covered for adults if rendered within a two-year period after the accidental injury. The two-year restriction may be waived for children under age 18. Actual treatment may be delayed if tooth/bone maturity is in question and standard industry protocols are followed. However, a treatment plan must be filed within six months of the accident and treatment must be completed within two years of active treatment commencement and prior to age 20. For the waiver to be granted, continuous coverage under the plan is required;
- the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face;
- dental services and dental appliances furnished when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- dental services to prepare the mouth for radiation therapy to treat head and neck cancer; and
- covered general anesthesia and hospitalization services for children under the age of 5, *covered persons* who are severely disabled, and *covered persons* who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the *covered person's* treating physician, that such services are required to effectively and safely provide dental care.

☞ **Helpful tip:** Information about coverage for impacted teeth can be found under **Surgery.**

☞ **Helpful tip:** Non-routine dental services are considered covered under *other covered services* and are subject to the medical calendar year deductible and out-of-pocket expense limit.

Diabetic equipment and education

Your health plan covers medical supplies, equipment, and education for diabetes care for all diabetics. This includes coverage for the following:

- insulin pumps;
- home glucose blood monitors;
- blood glucose test strips; and

- *outpatient* self-management training and education performed in person; including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional.

☞ **Helpful tip:** Insulin, syringes and lancets for diabetes care are covered under **Prescription Drugs.**

Diagnostic tests

Your health plan covers the following procedures when ordered by your doctor to diagnose a definite condition or disease because of specific signs and/or symptoms, including:

- radiology (including mammograms), ultrasound or nuclear medicine;
- laboratory and pathology services or tests;
- diagnostic EKGs, EEGs; and
- sleep studies.

Observation, diagnostic examinations, or diagnostic laboratory testing that involves a hospital *stay* is covered under *your health plan* only when:

- your medical condition requires that medical skills be constantly available;
- your medical condition requires that medical supervision by your doctor is constantly available; or
- diagnostic services and equipment are available only as an *inpatient.*

Dialysis

Your health plan covers dialysis treatment, which is the treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes hemodialysis and peritoneal dialysis.

Doctor visits and services

Your health plan covers:

- *visits* to a doctor's office or your doctor's *visits* to your home;
- *visits* to an urgent care center;
- *visits* to a hospital *outpatient* department or *emergency* room; and
- *visits* for shots needed for treatment (for example, allergy shots).

Early intervention services

Your health plan covers early intervention services for covered dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services ("DMH") as eligible for services under Part H of the Individuals with Disabilities Education Act. These services consist of:

- speech and language therapy;

- occupational therapy;
- physical therapy; and
- assistive technology services and devices.

Early intervention services for the population certified by DMH are those services listed above which are determined to be *medically necessary* by DMH and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without effecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not *medically necessary*.

Emergency room care

Your health plan covers *emergency* room *visits,* services, and supplies. If *you* are admitted to the hospital from the *emergency* room, the hospital *stays* must be reviewed by Anthem for medical services or by Magellan Behavioral Health for mental health services within 48 hours of admission. The *emergency* room doctor, a relative, or a friend can call for Hospital Admission Review (see page 11) in an *emergency*.

Home care services

Your health plan covers treatment provided in *your* home on a part-time or intermittent basis. This coverage allows for an alternative to repeated hospitalizations that will provide the quality and appropriate level of care to treat *your* condition. To ensure benefits, *your* doctor must provide a description of the treatment *you* will receive at home. *Your* coverage includes:

Home health services

- *visits* by a licensed health care professional, including a nurse, therapist, or home health aide; and
- physical, speech, and occupational therapy.

These services, which require medical necessity review, are only covered when your condition confines *you* to *your* home at all times except for brief absences.

Home infusion services

Home infusion therapy includes such services as the intravenous and parenteral administration of medication to patients as well as enteral and parenteral nutrition (see **Infusion therapy** on page 30).

Home private duty nurse's services

Your health plan covers the cost of medically skilled services of a currently licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in your home when the nurse is not a relative or member of your family. Your doctor must certify to *us* that the services are *medically necessary* for your condition, and not merely custodial in nature.

Hospice care services

Hospice care will be covered for *covered persons* diagnosed with a terminal illness who have a life expectancy of six months or less. Covered services include the following:

- skilled nursing care, including IV therapy services;
- drugs and other *outpatient* prescription medications for palliative care and pain management;
- services of a medical social worker;
- services of a home health aide or homemaker;
- short-term *inpatient* care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute *inpatient* care for the *covered person* in order to provide the *covered person's* primary caregiver a temporary break from caregiving responsibilities. Respite care may be provided only on an intermittent, non-routine and occasional basis and may not be provided for more than five days every 90 days;
- physical, speech, or occupational therapy (services provided as part of hospice care are not subject to dollar-limits);
- durable medical equipment;
- routine medical supplies;
- routine lab services;
- counseling, including nutritional counseling with respect to the *covered person's* care and death; and
- bereavement counseling for immediate family members both before and after the *covered person's* death.

Hospital services

Your health plan covers the hospital and doctors' services when *you* are treated on an *outpatient* basis, or when *you* are an *inpatient* because of illness, injury, or pregnancy. (See **Maternity** on page 21 for an additional discussion of pregnancy benefits.) *Your health plan* covers *medically necessary* care in a semi-private room or intensive or special care unit. This includes your bed, meals, special diets, and general nursing services.

In addition to your semi-private room, general nursing services and meals, *your health plan* covers *allowable charges* for *medically necessary* services and supplies furnished by the hospital when prescribed by your doctor or *provider.*

The hospital must meet the American Hospital Association's standards for registration as a hospital. Remember that your share of the cost of covered services will change if *you* use a doctor, *facility,* or other health care *provider* that is outside your network.

While *you* are an *inpatient* in the hospital, *your health plan* covers the *medically necessary* services rendered by doctors and other covered *providers.*

☞ **Helpful tip:** All inpatient hospital stays must be approved before each admission (see **Hospital Admission Review** on page 11).

Private room

Your health plan covers the private room charge if *you* need a private room because *you* have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your *inpatient* benefits would cover the hospital's charges for a semi-private room. If *you* choose to occupy a private room, *you* will be responsible for paying the daily differences between the semi-private and private room rates in addition to your *copayment* and *coinsurance* (if any). If the hospital has only private rooms, *your health plan* would cover an amount *we* determine is the most common semi-private room charge for hospitals in the community.

Maternity

Prenatal and newborn care

If *you* (or your covered dependent) become pregnant, *your health plan* provides several coverage features. Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered by *your health plan.*

☞ **Helpful tip:** See **Change in your number of eligible family members** on page 51 for details on when and how to enroll a newborn.

☞ **Helpful tip:** Remember to call or have your doctor call to notify us of your maternity admission. *You* may notify us as much as three months before delivery.

Your benefits include:

- use of the delivery room and care for normal deliveries;
- home *setting* covered with nurse midwives;
- anesthesia services to provide partial or complete loss of sensation before delivery;
- routine nursery care for the newborn during the mother's normal hospital *stay;*
- prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary;
- initial examination of a newborn and circumcision of a covered male dependent; and

- fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

If your doctor submits one bill for delivery, prenatal, and postnatal care services, payment will be made at the same level as *inpatient* professional *provider* services. If your doctor bills for these services separately your payment responsibility will be determined by the services received.

Baby Benefits SM'

You (or your covered dependent) are eligible to participate in *Baby Benefits.* This program is designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery. A *Baby Benefits* consultant is assigned to women identified as having greater risk of premature delivery. The consultant (a nurse or health educator) works with the mother and her doctor during the pregnancy to determine what may be needed to help achieve a full-term delivery. Education and counseling services are available to expectant mothers 24-hours a day, 365 days a year. Bilingual nurses, Language Line and Hearing Impaired Services allow patients to communicate with ease. As soon as pregnancy is confirmed, sign up for the program by calling **800-828-5891.** *You* will receive:

- a kit containing educational material on how to get proper prenatal care and identify signs of premature labor;
- a risk appraisal to identify signs of premature labor; and
- after delivery, a birth kit and child care book.

Medical equipment

Your health plan covers the rental (or purchase if that would be less expensive) of *durable medical equipment* required for therapeutic use when prescribed by your doctor. Also covered are maintenance and necessary repairs of *durable medical equipment* except when damage is due to neglect. Medical necessity review is required.

Coverage includes equipment such as:

- nebulizers;
- hospital-type beds;
- wheelchairs;
- traction equipment;
- walkers; and
- crutches.

Medical devices and appliances

Your health plan covers the cost of fitting, adjustment, and repair of the following items when prescribed by your doctor for *activities of daily living:*

- artificial limbs, including accessories;
- orthopedic braces;

- leg braces, including attached or built up shoes attached to the leg brace;
- arm braces, back braces, and neck braces;
- head halters;
- catheters and related supplies;
- orthotics, other than foot orthotics; and
- splints.

Medical necessity review is required.

Medical supplies

Medical supplies are covered under *your health plan* if they are prescribed by a covered *provider.* Medical necessity review is required. Examples of medical supplies include:

- allergy serum;
- oxygen and equipment (respirators) for its administration; and
- hypodermic needles and syringes.

Mental health and substance abuse treatment

Magellan Behavioral Health administers *your health plan's* mental health and substance abuse treatment benefits. Contact Magellan to obtain *preauthorization* for services.

Services may be provided in various settings or *levels of care* depending upon the treatment that is needed. Care Managers approve the appropriate *levels of care* based on your diagnosis and Magellan's medical necessity criteria. *Acute care* requires the most intensive level of skills and services, and is provided in a psychiatric hospital or a detoxification unit. These facilities are licensed as hospitals and provide 24-hour medical and nursing care.

Partial day services combine intensive treatment in a medically supervised setting, with the opportunity for the patient to return home or to another residential setting at night. Care includes individual, group, family, educational, and rehabilitation services. These programs usually offer services three to five times per week for more than several hours per day.

Outpatient treatment is the most frequently prescribed level of care provided on an individual, group, or family basis in an office setting. Therapists include licensed social workers, master's level psychiatric nurses, doctoral level psychologists, or psychiatrists.

Employee assistance program (EAP)

The EAP is a confidential assessment, referral, and short-term problem-solving service available to you and covered family members. You are automatically enrolled in the program as part of *your health plan* coverage. The EAP helps you deal with problems affecting personal and work life, such as:

- conflicts within the family and workplace;
- personal and emotional concerns;

- alcohol and substance abuse;
- financial and legal problems;
- elder and child care; and
- career concerns and other challenges.

Your health plan covers up to four counseling sessions per incident at no cost to you. Contact Magellan Behavioral Health at **800-775-5138** for assistance.

Medication Management

Visits to your doctor are covered to make sure that medication *you* are taking for a mental health or substance abuse problem is working and that the dosage is right for you.

Prescription drugs (mandatory generic program)

Your health plan covers *prescription drugs* if received through a pharmacy or a hospital. If *you* receive *prescription drugs* from your hospital, they will be covered as a hospital service.

Also covered are *prescription drugs* and devices approved by the Food and Drug Administration (FDA) for use as contraceptives.

Benefits provide for insulin and diabetic supplies to treat diabetes. This includes coverage for the following:

- lancets; and
- hypodermic needles and syringes.

Your prescription drug benefits at network pharmacies

Your *prescription drug* card benefits cover prescriptions obtained from a pharmacist. *You* may receive up to a 34-day supply of medicine for an original prescription or refill for up to one year. Your benefits also include a 35-68 day supply for two times the retail pharmacy *copayment* amount and a 69-102 day supply for three times the retail pharmacy *copayment* amount. Simply choose a pharmacy that participates in the network and show your ID card to receive benefits.

To find a pharmacy that participates in the network:

- go to **www.anthem.com** on the Web. Click on Search the Provider Directory. Choose Virginia, then choose the Commonwealth of Virginia and The Local Choice directory link;
- refer to the printed directory of network *providers;*
- check with your local pharmacy to see if they participate in the network; or
- call Anthem's Member Services.

Network pharmacies will automatically file claims for *you* and charge *you* only the required amount under your health care plan for covered prescriptions. At non-network pharmacies you pay the total price of the drug and then file a Prescription Drug Reimbursement Form. Reimbursement is limited to the *allowable charge* for the drug minus your *copayment* amount.

You must have used 75% of your prescription before it can be refilled. In the event that your physician increases the amount of your dosage, your physician should provide a new prescription order to be filled by your pharmacy.

Anthem Blue Cross and Blue Shield receives financial credits from drug manufacturers based on the total volume of claims processed for their products utilized by Anthem members. A portion of these credits is used to reduce plan costs and a portion is used by Anthem as part of its fee for administering the program. Reimbursements to pharmacies are not affected by these credits.

First-tier, second-tier, and third-tier drugs

The amount *you* will pay for a *prescription drug* depends on whether the drug *you* receive is *a first-tier, second-tier,* or *third-tier drug.* Refer to the **Summary of benefits** to determine your *copayment* amounts. *You* may request the brand name drug, and pay the difference in the *allowable charge* between the generic and the brand name drug, in addition to your *second-tier* or *third-tier copayment.* By law, generic and brand name drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves *you* and *your health plan* money, yet provides the same quality.

The determination of whether a particular drug is a *first-tier, second-tier, or third-tier drug* is made for the plan by Anthem in its sole discretion. In exercising its discretion, Anthem will consider the absolute cost of a drug, the relative cost of a drug within its therapeutic class, the availability of over-the-counter alternatives, and certain clinical economic factors. The plan reserves the right, in its sole discretion, to move any *prescription drug* from one tier to another.

☞ **Helpful tip:** Find out a drug's tier assignment on the Web at **www.anthem.com** under Search the Drug Listing.

Prior authorization

Your health plan requires prior review of selected drugs before payment is authorized. Your doctor has a list of drugs that require special approval. You may also view the list on the Web at **www.anthem.com** under Search the Drug Listing. This list is periodically modified. A written prior authorization request, including drug name, quantity per day and strength, period of time the drug is to be administered, medical condition for which the drug is being prescribed, the patient's name, ID number, date of birth, and relationship to the employee, must be sent by your doctor along with applicable medical records to:

Anthem Blue Cross and Blue Shield
Drug Prior Authorization
P. O. Box 85040
Richmond, VA 23261-5040

You will receive a written notice when a prescription is denied for coverage. Your doctor will be notified of both approval and denial decisions.

If prescribed in compliance with established statutes pertaining to patients with intractable cancer pain, *your health plan* will not deny *prescription drugs* (or *inpatient* or IV therapy drugs) used in the treatment of cancer pain on the basis that the dosage exceeds the recommended dosage of the pain relieving agent.

Medco Health Home Delivery Services

You may also purchase up to a 90-day supply of your *maintenance medication* through the mail and have your prescription delivered directly to your home. To receive your *maintenance medicine* prescription by mail, follow these 3 steps:

1. Ask your doctor to prescribe a 90-day supply of your *maintenance medicine* plus refills. If *you* need the medicine immediately, ask your doctor for two prescriptions: one to be filled right away and another to send to Medco Health Home Delivery Services.
2. Mail your 90-day prescription, a check to cover your copayment(s), the Home Delivery Order Form and Patient Profile questionnaire in the home delivery window envelope to Medco Health Home Delivery Services. The forms are available on the Web at **www.medcohealth.com** , from your b*enefits administrator,* or from Anthem Member Services.

You will receive your *prescription drugs* via first class mail or UPS approximately 14 days from the date *you* sent your order.

☞ **Helpful tip:** We suggest that you order your refill two weeks before you need it to avoid running out of your medication.

☞ **Helpful tip:** If you have questions concerning the home delivery services program you can call Medco Health Home Delivery Services customer service at **800-355-8279** or visit **www.medcohealth.com.**

You will receive refill forms and a notice that shows the number of refills your doctor ordered in the package with your drugs. To order refills, *you* must have used 75% of your prescription. Mail the refill notice and the appropriate *copayment* amount to Medco Health Home Delivery Services in the envelope provided, or call **800-4REFILL (800-473-3455).**

When you may need to file a claim

You may need to file your own claim if:

- your prescription is filled by a non-participating pharmacy;
- *you* need to have a prescription filled before *you* receive your card; or
- *you* have a prescription that requires special prior approval, but *you* need the prescription filled immediately.

Contact Anthem's Member Services if *you* need a Prescription Drug Reimbursement Form or if *you* have any questions about your drug program and related procedures.

To file a claim, follow these 3 steps:

1. Complete the Prescription Drug Reimbursement Form available online at **www.anthem.com** or from Anthem Member Services. If possible, ask the pharmacist to complete the pharmacy section of the form and sign it.
2. Pay for the prescription.
3. Mail your claim form to the address on the back of the form within 12 months of purchasing the prescription.

Shots (Injections)

Your health plan covers therapeutic injections (shots) that a *provider* gives to treat illness or pregnancy-related conditions (e.g., allergy shots). In addition, *you* have coverage for immunizations and self-administered injections.

Some injections may be administered by pharmacies that are authorized to perform this service. Contact the pharmacy to determine if they are authorized to do so.

Skilled nursing facility stays

Your coverage includes benefits for skilled nursing home *stays*. Coverage for your *stay* requires prior approval. Your doctor must submit a plan of treatment that describes the type of care *you* need. The following items and services will be provided to *you* as an *inpatient* in a skilled nursing bed of a *skilled nursing facility:*

- room and board in semi-private accommodations;
- rehabilitative services; and
- drugs, biologicals, and supplies furnished for use in the skilled nursing facility, and other medically necessary services and supplies.

Custodial or residential care in a *skilled nursing facility* or any other facility is not covered except as rendered as part of Hospice care.

Spinal manipulation and other manual medical interventions

Your health plan covers spinal manipulation services (manual medical interventions) and associated evaluation and management services, including manipulation of the spine and other joints, application of manual traction and soft tissue manipulations.

Surgery

General surgery

Surgery charges are covered when treatment is received at an *inpatient, outpatient* or ambulatory surgery *facility,* or doctor's office. *Your health plan* will not pay separately for pre- and post-operative services.

Morbid obesity treatment

Your health plan covers treatment of morbid obesity through gastric bypass, or other methods recognized by the National Institutes of Health (NIH). Medical necessity review is required. Coverage is restricted to surgical procedures and does not include weight control dietary supplements, except when prescribed in conjunction with the treatment of morbid obesity. According to the NIH guidelines, gastric bypass surgery is effective for the long-term reversal of morbid obesity for a patient who:

- weighs at least 100 pounds over or twice the ideal body weight;
- has a body mass index equal to or greater than 35 kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- has a body mass index of 40 kilograms per meter squared without such comorbidity.

Reconstructive breast surgery and mastectomy

Mastectomy, or the surgical removal of all or part of the breast, is a covered service. Also covered are:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; and
- prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the *covered person.*

Reconstructive breast surgery done at the same time as a mastectomy or following a mastectomy to re-establish symmetry between two breasts is also covered.

Oral surgery

Your health plan covers oral surgery for:

- surgical removal of impacted teeth;
- maxillary or mandibular frenectomy when not related to a dental procedure;
- alveolectomy when related to tooth extraction;
- orthognathic surgery that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part;
- surgical services on the hard or soft tissue in the mouth when the main purpose is **not** to treat or help the teeth and their supporting structures; and

- the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.

Medical necessity review is required for non-routine oral surgery.

Organ and tissue transplants, transfusions

Your health plan covers some but not all organ and tissue transplants. Medical necessity review is required. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan. However, benefits for these services are limited only to those not available to the donor from any other source, including, but not limited to, other insurance coverage or any government program.

When only the donor is a covered person under the plan, inpatient hospital services and outpatient services will not be eligible for reimbursement if rendered in anticipation of inpatient services that are provided to the donor in connection with the transplant procedure.

Covered services for the identification of a suitable donor to a covered person for an allogeneic bone marrow transplant will include a computer search of established bone marrow registries and laboratory testing necessary to establish compatibility of potential donors. Donors may be from the patient's immediate family or have been identified through the computer search. These services must be ordered by a doctor qualified to provide allogeneic transplants.

The following major organ and tissue transplants, and any medical complications from such services, are the only organ and tissue transplant services covered by your plan:

- autologous parathyroid transplant;
- autologous islet cell transplant;
- blood transfusion;
- bone and cartilage grafting;
- corneal transplant;
- heart or heart-lung transplant;
- kidney transplant;
- liver transplant or liver lobe;
- pancreas transplant;
- pancreas and kidney combined transplant;
- single or double lung or lobe transplant;
- skin grafting; and
- small bowel or small bowel transplant, and liver transplant.

Therapy

Your health plan covers physical, occupational, speech, and respiratory therapy when the treatment is *medically necessary* for your condition and provided by a licensed therapist. The following therapies are also covered.

Cardiac rehabilitation therapy

Your health plan includes benefits for cardiac rehabilitation, which is the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease.

Chemotherapy

Your health plan covers the treatment of malignant disease by chemical or biological antineoplastic agents.

High dose chemotherapy and/or *high dose* radiation, as well as any supporting allogeneic or syngeneic bone marrow transplants or other forms of allogeneic or syngeneic stem cell rescue, will be covered by *your health plan* when used to treat specified conditions listed in **Exhibit A.**

High dose chemotherapy and/or *high dose* radiation and any supporting autologous bone marrow transplants or other forms of autologous stem cell rescue will be covered by *your health plan* when used to treat specified conditions listed in **Exhibit A-1.**

Infusion therapy

Your health plan covers infusion therapy, which is treatment by placing therapeutic agents into the vein, including intravenous feeding. This also includes enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract.

Occupational therapy

Your health plan covers occupational therapy following disease, injury, or loss of limb. Occupational therapy is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing.

Physical therapy

Your health plan covers physical therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb. Your coverage includes benefits for physical therapy to treat lymphedema.

Radiation therapy

Your health plan covers radiation therapy, including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.

Respiratory therapy

Your health plan covers respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

Speech therapy

Your health plan covers speech therapy, which is treatment for the correction of a speech impairment which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment.

☞ **Helpful tip:** It is suggested that you obtain medical necessity review prior to receiving occupational, physical or speech therapy to ensure the services are *medically necessary*.

Vision correction after surgery or accident

Your health plan covers the cost of prescribed eyeglasses or contact lenses only when required as a result of surgery, or for the treatment of accidental injury. Services for exams and replacement of these eyeglasses or contact lenses will be covered only if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if:

- prescribed to replace the human lens lost due to surgery or injury;
- "pinhole" glasses are prescribed for use after surgery for a detached retina; or
- lenses are prescribed instead of surgery in the following situations:
  - contact lenses are used for the treatment of infantile glaucoma;
  - corneal or scleral lenses are prescribed in connection with keratoconus;
  - scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or
  - corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.

If you selected the Vision, hearing and expanded dental option, see the **Optional benefits** section on page 82 for a description of your routine vision benefits.

Wellness services

Well child care

Well child benefits include coverage for routine care, screenings, checkups, and immunizations for your child through age 6. These services are based on the recommendations of the American Academy of Pediatrics, and include the following:

- complete physical examinations, developmental assessment and guidance;

- immunizations such as diphtheria, tetanus, pertussis (DTP), polio, measles, mumps, rubella (MMR), hemophilus vaccine (HIB), hepatitis B, varicella virus (chicken pox) vaccine, pneumococcal conjugate vaccine, influenza, and other immunizations as may be prescribed by the Commissioner of Health; and
- certain laboratory and screening tests, including hearing and vision tests required for a preschool physical exam.

The American Academy of Pediatrics recommends the following schedule for well child care visits:

Birth	2 months	9 months	18 months	4 years
2-4 days	4 months	12 months	2 years	5 years
2-4 weeks	6 months	15 months	3 years	6 years

☞ **Helpful tip:** These benefits are for well children. Treatment of an illness or emergency is covered according to the terms described for specific conditions or treatments.

Routine wellness and preventive care

Your health plan provides routine wellness benefits. For covered members age 7 and older, benefits are provided for an annual checkup, routine laboratory and radiological services, and immunizations. This allows *you* and your doctor to choose the routine care services that *you* and covered family members need most.

Wellness coverage under *your health plan* also includes:

- an annual gynecological exam and Pap test including coverage for annual testing performed by any FDA-approved gynecologic cytology screening technologies;
- one annual mammography screening for patients age 35 or older;
- prostate exams (digital rectal exams) and an annual Prostate Specific Antigen test for enrollees ages 40 and older; and
- colorectal cancer screenings, for patients age 40 or older, such as:
  - an annual fecal occult blood test;
  - flexible sigmoidoscopy;
  - colonoscopy; or
  - barium enema

☞ **Helpful tip:** Charges for routine laboratory, tests, shots and x-rays in conjunction with your annual check up visit apply toward the maximum for Routine Wellness Care described in the **Summary of benefits.**

What is not covered (Exclusions)

This alphabetical list of services and supplies that are excluded from coverage by *your health plan* will not be covered in any case.

A

Your coverage does not include benefits for **acupuncture**.

B

Your coverage does not include benefits for **biofeedback therapy.**

C

Your coverage does not include benefits for *high dose* **chemotherapy** and/or *high dose* radiation, any supporting autologous, allogeneic or syngeneic bone marrow transplants or stem cell rescue, and any medical problems that result from them except as specified in the Therapy section on page 30 and the exhibits on pages 74 and 75. In addition, your coverage does not include benefits for the following:

- high dose chemotherapy with allogeneic stem cell support after a prior failed course of high dose chemotherapy with autologous stem cell support;
- tandem transplants, which are two courses of high dose chemotherapy with allogeneic, autologous or syngeneic stem cell support, which are typically administered at intervals of two to six months, contingent on recovery from prior toxicities; and
- autologous, allogeneic, or syngeneic bone marrow transplants or stem cell rescue together with and when used in conjunction with low dose chemotherapy, and any medical problems that result from them, except allogeneic bone marrow transplants involving the use of low doses of chemotherapy when used to treat conditions identified on Exhibit A on page 74.

Your coverage does not include benefits for:

- Over-the-counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, and ice bags; or
- benefits for, or related to, **cosmetic surgery or procedures,** including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. A cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process, or to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

D

Your coverage does not include benefits for the following **dental** services:

- services rendered after the date of termination of the covered person's coverage. There is one exception. Covered prosthetic services which are prepped or ordered before the termination date are covered if completed within 30 days following the termination date;
- gold foil restorations;
- athletic mouth guards;
- temporary dentures, crowns or duplicate dentures;
- oral, inhalation or intravenous (IV) sedation;
- bleaching of discolored teeth;
- dental pit/fissure sealants on other than first and second permanent molars;
- root canal therapy on other than permanent teeth;
- pulp capping (direct or indirect);
- upgrading of working dental appliances;
- precision attachments for dental appliances;
- tissue conditioning;
- separate charges for infection control procedures and procedures to comply with OSHA requirements;
- separate charges for routine irrigation or re-evaluation following periodontal therapy;
- analgesics (nitrous oxide);
- diagnostic photographs;
- periodontal splinting and occlusal adjustments for periodontal purposes;
- occlusal analysis;
- controlled release of medicine to tooth crevicular tissues for periodontal purposes;
- tooth desensitizing treatments;
- care by more than one dentist when you transfer from one dentist to another during the course of treatment;
- care by more than one dentist for one dental procedure; and
- any services not listed as covered in the Dental services section on page 15, or on page 82 if you purchased the Expanded dental option.

E

Your coverage does not include benefits for **educational** or teacher services except as specified in this booklet.

Your medical coverage does not include benefits for **experimental/investigative** procedures, as well as services related to or complications from such procedures, except for clinical trial costs for cancer. The criteria for deciding whether a service is experimental/investigative or a clinical trial cost for cancer is described in **Exhibit B.** Your mental health and substance abuse treatment coverage does not include benefits for **experimental/investigative** services or supplies as determined by Magellan Behavioral Health in its sole discretion. The criteria for this determination is whether any supply or drug has received final approval to market by the U.S. Food and Drug Administration; whether there is sufficient information in the peer-reviewed medical and scientific literature for Magellan to judge safety

and efficacy; whether available scientific evidence shows a good effect on health outcomes outside of a research setting; and whether the service or supply is safe and effective outside a research setting as a current diagnostic or therapeutic option.

F

Your coverage does not include benefits for **family planning** services. These include:

- services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception, including any drugs administered in connection with these procedures;
- drugs used to treat infertility; or
- services for abortions, except in the following circumstances and only if not otherwise contrary to law: when medically necessary to save the life of the mother; when the pregnancy occurs as a result of rape or incest which has been reported to a law enforcement or public health agency; or when the fetus is believed to have an incapacitating physical deformity or incapacitating mental deficiency which is certified by a provider.

Your coverage does not include benefits for palliative or cosmetic **foot care** including:

- flat foot conditions;
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet;
- foot orthotics;
- subluxations of the foot;
- corns;
- bunions (except capsular or bone surgery);
- calluses;
- care of toenails;
- fallen arches;
- weak feet;
- chronic foot strain; or
- symptomatic complaints of the feet.

G

Except as otherwise provided, your coverage does not include benefits for **genetic testing** for screening purposes other than fetal screenings. Prophylactic services are not covered. Prophylactic services include services for potential illnesses that may result from genetic pre-disposition or family history.

H

Your coverage does not include benefits for routine **hearing care** except as covered on page 32 of this booklet, or hearing aids or exams for these devices. If you have selected the Vision, hearing and expanded dental option, additional hearing benefits are described on page 82.

Your coverage does not include benefits for the following **home care** services:
- homemaker services;
- maintenance therapy;
- food and home-delivered meals; or
- custodial care and services.

Your coverage does not include benefits for the following **hospital** services:
- guest meals, telephones, televisions, and any other convenience items received as part of your *inpatient stay;*
- care by interns, residents, house physicians, or other *facility* employees that are billed separately from the *facility;*
- a private room unless it is *medically necessary.*

M

Your coverage does not include benefits for **medical equipment, appliances and devices, and medical supplies** that have both a non-therapeutic and therapeutic use, such as:
- exercise equipment;
- air conditioners, dehumidifiers, humidifiers, and purifiers;
- hypoallergenic bed linens;
- whirlpool baths;
- handrails, ramps, elevators, and stair glides;
- telephones;
- adjustments made to a vehicle;
- foot orthotics;
- changes made to a home or place of business; or
- repair or replacement of equipment you lose or damage through neglect.

Your coverage does not include benefits for services and supplies if they are deemed not **medically necessary** as determined by Anthem or Magellan Behavioral Health at their sole discretion. Nothing in this exclusion shall prevent you from appealing Anthem or Magellan's decision that a service is *medically necessary.*

However, if *you* receive *inpatient* or *outpatient* services that are denied as not *medically necessary,* or are denied for failure to obtain the required preauthorization, the following professional provider services that you receive during your *inpatient stay* or as part of your *outpatient* services will not be denied under this exclusion in spite of the medical necessity denial of the overall services:

For *inpatients*

1. services that are rendered by professional providers who do not control whether *you* are treated on an *inpatient* basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.
2. services rendered by your attending provider other than *inpatient* evaluation and management services provided to *you. Inpatient* evaluation and management services include routine visits by your attending

provider for purposes such as reviewing patient status, test results, and patient medical records. *Inpatient* evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your attending provider.

For *outpatients* - services of pathologists, radiologists and anesthesiologists.

Your coverage with Magellan Behavioral Health, in addition to services shown as not covered throughout this section, does not include benefits for **mental health and substance abuse treatment services** as follows:

- inpatient treatment or inpatient stay for conditions requiring only observation, diagnostic examinations, or diagnostic laboratory testing;
- inpatient treatment which might safely and adequately be rendered in a home, provider's office, or at any lesser level of institutional care;
- laboratory tests and prescription drugs (may be covered under medical);
- services provided as a result of failure or refusal to obtain treatment or follow a plan of treatment prescribed or directed by a practitioner;
- court ordered examinations or care unless medically necessary;
- routine examinations or testing (may be covered under medical);
- illness resulting from or relating to a felony;
- treatment of organic brain syndrome;
- treatment of anti-social personality, inadequate personality, sexual deviation or sexual dysfunction, social maladjustment without apparent psychiatric disorder, group delinquent reaction of childhood, mental retardation, Tourette's disorder, learning disabilities, and conduct and oppositional disorders;
- examination of an inpatient that is not related to the mental health or substance abuse diagnosis;
- marital counseling, education therapy, speech therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, and recreational therapy;
- psychoanalysis to complete degree or residency requirements;
- pastoral counseling;
- psychological testing for educational purposes;
- hypnosis for disorders not classified in the Diagnostic and Statistical Manual of Mental Disorders;
- treatment of conditions not recognized in the Diagnostic and Statistical Manual of Mental Disorders such as adult child of alcoholic families, "ACOA", or co-dependency; conditions classified as "V-codes" in the Diagnostic and Statistical Manual of Mental Disorders; and conditions arising from developmental disorders (mental retardation, academic skills disorders, motor skills disorders, and organic brain disorders in which demonstrable and significant improvement from psychiatric treatment is unlikely).

N

Your coverage does not include benefits for **nutritional counseling** and related services, except when provided as part of diabetes education.

O

Your coverage does not include benefits for care of **obesity** or services related to weight loss or dietary control including weight reduction therapies/activities, even if there is a related medical problem. The exception to this exclusion is morbid obesity as defined on page 28 of this book. Coverage is provided for treatment of morbid obesity through gastric bypass surgery or other methods recognized by the National Institutes of Health (NIH) as effective treatment for the long-term reversal of morbid obesity for a patient who:

- weighs at least 100 pounds over or twice the ideal body weight;
- has a body mass index equal to or greater than 35 kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- has a body mass index of 40 kilograms per meter squared, without such comorbidity.

Your coverage does not include benefits for **organ or tissue transplants** including complications caused by them, except as outlined on page 29 of this book.

P

Your coverage does not include benefits for **paternity testing.**

Your ***prescription drug*** benefit does not include coverage for:

- over-the-counter drugs;
- any per unit, per month quantity over the plan's limit;
- drugs used mainly for cosmetic purposes;
- drugs that are experimental, investigational, or not approved by the FDA (see page 34);
- cost of medicine that exceeds the *allowable charge* for that prescription;
- drugs for weight loss, except in conjunction with covered treatment of morbid obesity;
- stop smoking aids;
- therapeutic devices or appliances;
- injectable *prescription drugs* that are supplied by a *provider* other than a pharmacy;
- charges to inject or administer drugs;
- drugs not dispensed by a licensed pharmacy;
- drugs not prescribed by a licensed *provider;*
- any refill dispensed after one year from the date of the original prescription order;
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies; or
- medicine furnished by any other drug or medical service.

Your coverage does not include benefits for **private duty nurses** in the *inpatient* setting.

R

Your coverage does not include benefits for rest cures, custodial, **residential,** halfway house or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether *you* receive active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic services. Your coverage does not include benefits for care from institutions or facilities that are licensed solely as **residential treatment centers,** intermediate care facilities, or other non-skilled, sub-acute inpatient settings.

S

Your coverage does not include benefits for **services or supplies** as follows:

- ordered by a doctor whose services are not covered under *your health plan;*
- care of any type given along with the services of an attending *provider* whose services are not covered;
- not listed as covered under *your health plan;*
- not prescribed, performed, or directed by a *provider* licensed to do so;
- received before the *effective date* of coverage or after a covered person's coverage ends;
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms;
- for travel, whether or not recommended by a physician;
- given by a member of the covered person's immediate family;
- provided under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not *you* waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. Anthem will pay for covered services when these program benefits have been exhausted;
- provided under a U. S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government;
- received from an employer mutual association, trust, or a labor union's dental or medical department; or
- for diseases contracted or injuries caused because of participation in war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.

Your coverage does not include benefits for **services** for which a charge is not usually made. This includes services for which *you* would not have been charged if *you* did not have health care coverage.

Your coverage does not include benefits for:

- amounts above the *allowable charge* for a service;
- self-administered services or self-care;
- self-help training; or
- biofeedback, neurofeedback, and related diagnostic tests.

Your coverage does not include benefits for surgeries for **sexual dysfunction.** In addition, your coverage does not include benefits for services for **sex transformation.** This includes medical and mental health services.

Your coverage does not include benefits for the following **skilled nursing** *facility stays:*
- treatment of psychiatric conditions and senile deterioration; or
- *facility* services during a temporary leave of absence from the *facility.*

Your coverage does not include benefits for services related to **smoking cessation,** including stop smoking aids or services of stop smoking clinics.

T

Your coverage does not include benefits for the following **therapies**:
- physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services;
- group speech therapy;
- group physical therapy; or
- recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

V

Your coverage does not include benefits for the following **vision** services:
- services for radial keratotomy and other surgical procedures to correct nearsightedness and/or farsightedness. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics;
- sunglasses of any type;
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer; or
- any other vision services not specifically listed as covered.

If you have selected the Vision, hearing and expanded dental option, additional vision benefits are described on page 82.

W

Your coverage does not include benefits for services or supplies if they are for **work-related** injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. This exclusion applies even if *you* waive your right to payment under

these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the *covered person* reaches a settlement with his or her employer or the employer's insurer or self-insurance association because of the injury or disease.

Claims and payments

Your health plan considers the charge to be incurred on the date a service is provided. This is important because *you* must be actively enrolled on the date the service is provided. Also, the dates of service will affect your *deductible* (if any) and other minimums described in the **Summary of benefits** and in this section.

☞ **Helpful tip:** Covered services you receive that are applied to your deductible during the fourth quarter of any calendar year will count toward your deductible in the next calendar year. For example, if you satisfy $100 toward your deductible in October, the deductible for the next calendar year would be reduced by the same amount.

Your out-of-pocket expense limit

Your health plan protects *you* from large out-of-pocket expenses by limiting the amount *you* spend out of your own pocket each year. Once the calendar year limit on *your health plan* is reached, almost all other covered expenses are paid in full (100% of the *allowable charge)* for the rest of the calendar year.

If you have not purchased the out-of-network option

What counts toward your out-of-pocket expense limit

- deductible, copayments and coinsurance for covered services from *providers* and *facilities* in your Anthem, BlueCard PPO, or Magellan Behavioral Health networks.

What does not count toward your out-of-pocket expense limit

- expenses for services or supplies not covered by your health plan;
- amounts above the allowable charge;
- amounts above the health plan limits; and
- copayments and coinsurance for outpatient prescription drugs, routine and expanded dental services, and the optional routine vision and hearing benefits.

If you have purchased the out-of-network option

What counts toward your out-of-pocket expense limit

- deductible, copayments and coinsurance for covered services from *providers* and *facilities* in your Anthem, BlueCard PPO, or Magellan Behavioral Health networks and providers and facilities **not** in the networks.

What does not count toward your out-of-pocket expense limit

- the plan's 25% payment reduction for covered services from *providers* and *facilities* not in your Anthem, BlueCard PPO, or Magellan Behavioral Health networks;
- amounts above the allowable charge;
- amounts above the health plan limits;
- copayments and coinsurance for outpatient prescription drugs, routine and expanded dental services, and the optional routine vision and hearing benefits; and
- expenses for services or supplies not covered by *your health plan.*

Lifetime maximum on benefits

Your health plan includes a lifetime maximum on *other covered services* for *you* and each of your eligible dependents as long as this coverage through *your health plan* is in effect (see page 1). *Other covered services* include ambulance travel, medical equipment, etc. See the full description on page 82. Once an individual reaches the lifetime maximum, no additional payments for *other covered services* will be made by *your health plan* for that individual.

How a claim is paid

Network and participating providers and facilities

If *you* go to a network or participating *provider* or *facility,* we will pay the *provider* or *facility* directly. If *coinsurance* is applicable to covered services rendered by a *facility, you* will not have to pay until Anthem, Magellan Behavioral Health, or the *facility* notifies *you* of the amount due, which is based on Anthem or Magellan's negotiated payment arrangement with the *facility.*

In all cases, the payment relieves Anthem, Magellan and *your health plan* of any further liability for the service.

When you must file a medical claim with Anthem

Network *providers* file claims on your behalf. *You* may have to file a claim if *you* receive care from a *provider* or *facility* that does not participate in the network.

You will have to file a claim if *you* receive care billed by someone other than a doctor or hospital, or if the *provider* cannot file a claim for *you.* To file a claim follow these 3 steps:

1. Download a claim form at **www.anthem.com** or call **804-355-8506** in Richmond or **800-552-2682** to order a claim form, or request one from your *benefits administrator.*
2. Please include the completed and signed claim form and any itemized bills for covered services. Each itemized bill must contain the following:
    - name and address of the person or organization providing services or supplies;

- name of the patient receiving services or supplies;
- date services or supplies were provided;
- the charge for each type of service or supply;
- a description of the services or supplies received; and
- a description of the patient's condition (diagnosis).

In addition, private duty nursing bills must include the professional status of the nurse (for example, RN for registered nurse), the attending physician's written certification that the services were *medically necessary,* and the hours the nurse worked.

3. Send the completed claim form and any itemized bills for covered services to:
   Anthem Blue Cross and Blue Shield
   P. O. Box 27401
   Richmond, VA 23279

When you must file a mental health claim with Magellan

If you have purchased the COVA Care Out-of-network option and you self-refer, you may have to file a claim for covered mental health and substance abuse treatment. The provider may also ask you to pay the bill at the time you receive covered services. If this happens, pay the provider and submit a claim and an itemized bill to Magellan for reimbursement. Call **800-775-5138** to request a claim form.

Be sure the itemized bill is on the provider's letterhead and that it includes:
- a description of symptoms and treatment;
- the charges for the services performed;
- the date of service; and
- your name and membership number.

Mail your completed information to:

Magellan Claims
Commonwealth of Virginia Claims
P. O. Box 13000
Tallahassee, FL 32317

Payment for covered services will be sent directly to you. You will also receive an Explanation of Health Care Benefits (EOHB) anytime we review a claim. The EOHB is not a bill. It is documentation of the action taken on your claim. After we receive a properly completed claim form, we typically process the claim within 15 days.

There may be instances when additional information is needed to make a final decision about payment. In these instances, we will send you a notice explaining the reason for the delay. We will make a decision within 30 days of receiving the additional information.

Timely filing of claims

No claim (proof of loss) will be paid if we receive it more than 12 months after the date of service, except in the absence of legal capacity of the *covered person.* There is one exception. For *other covered services* no claim will be paid if received more than 12 months after the end of the calendar year in which the *other covered services* were received.

When your claim is processed

Your health plan may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by you or the provider furnishing the additional information. You or your provider must submit the additional information to us within either 15 months of the date of service or 45 days from the date you were notified that the information is needed, whichever is later. Once your claim has been processed by *your health plan,* you will receive written notification of the coverage decision.

When you are covered by more than one health plan

Coordination of benefits (COB)

Coordination of benefits (COB) rules apply when *you* or members of your family have additional health care coverage through other group health plans, including:

- group insurance plans, including other Blue Cross and Blue Shield plans or HMO plans;
- labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax-supported or government program to the extent permitted by law.

Primary coverage and secondary coverage

When a *covered person* is also enrolled in another group health plan, one coverage will be primary and one will be secondary. The decision of which coverage will be primary or secondary is made using the order of benefit determination rules. Highlights of these rules are described below:

- If the other coverage does not have COB rules substantially similar to this health plan's, the other coverage will be primary.
- If a *covered person* is enrolled as the named insured under one coverage and as a dependent under another, generally the one that covers him or her as the named insured will be primary.
- If a *covered person* is the named insured under both coverages, generally the one that covers him or her for the longer period of time will be primary.
- If the *covered person* is enrolled as a dependent child under both coverages (for example, when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the calendar year will be the primary.
- Special rules apply when a *covered person* is enrolled as a dependent child under two coverages and the child's parents are separated or divorced. Generally, the coverage of the parent or step-parent with custody will be primary. However, if there is a court order that requires one parent to provide for medical expenses for the child, that parent's coverage will be primary. If there is a court order that states that the parents share joint custody without designating that one of the parents is responsible for medical expenses, the coverage of the parent whose birthday falls earliest in the calendar year will be primary.

When this health plan provides secondary coverage, *we* first calculate the amount that would have been payable had this health plan been primary. Then *we* reduce this amount so that the combination of the primary plan's payment and this health plan's payment does not exceed *our* allowable charge. When the primary coverage provides benefits in the form of services rather than payment, a reasonable cash value of the services will be assigned and then considered to be the benefit payment. In no event will this health plan pay more in benefits as secondary coverage than it would have paid as primary coverage.

Overpayment of benefits

If *your health plan* overpays benefits because of COB, *your health plan* has the right to recover the excess from:

- any person to, or for whom such payments were made;
- any insurance company; or
- any other organization.

You will be required to cooperate with *your health plan* to secure this right.

Eligibility, enrollment and changes

Who is eligible for coverage

You are eligible for coverage if you are a full-time, salaried, classified employee or regular, full-time, salaried faculty. Your eligible dependents also may be covered. Retirees, LTD participants and survivors may also be eligible for coverage as described later in this section.

You may choose your type of membership as follows:
- Employee/retiree single to cover yourself only
- Employee/retiree plus one to cover yourself and one eligible dependent
- Family to cover yourself and two or more eligible dependents

Your eligible dependents

The following individuals are eligible for coverage under your health plan:
- legally married spouse
- unmarried, biological, or legally adopted children, or children placed in the home under a pre-adoptive agreement approved by the Department of Human Resource Management. The unmarried child(ren) must live at home and be eligible to be claimed on the parents' federal income tax return. There are exceptions, such as a child attending school full-time away from home, or living with the other parent if the employee is divorced.
- unmarried stepchildren living full time with the employee in a parent-child relationship and who are claimed as a dependent on member's federal tax return
- other children, on an exception basis, if they are in the permanent, court-ordered custody of the member
- disabled children, if the qualifying disability was diagnosed prior to the loss of eligibility for coverage due to age, and has been approved by the plan administrator. Enrollment must occur within 31 days of loss of coverage as dependent children due to age. A child who later recovers is no longer eligible and may not re-enroll.

Eligibility for dependent children is permitted as follows:
- a dependent child under age 23 may be covered until the last day of the calendar year in which the child turns age 23, or the end of the month in which the child marries or becomes self-supporting, whichever occurs first.
- a dependent child with a disability may continue to have coverage under your health plan if he or she is incapable of self-support because of a severe physical or mental disability diagnosed while the child is enrolled in your health plan. Application to continue coverage must occur within 31 days of the time the child becomes ineligible for coverage due to age.

Coverage for retirees and long term disability (LTD) participants

Retirees and LTD participants who enroll within 31 days of starting retirement or losing eligibility for coverage as an active employee may be eligible for coverage under this plan until they become eligible for Medicare (either due to age or disability). Dependent eligibility for the retiree group does not differ

from that of active employees except as noted for non-annuitant survivors (see "When the member dies"). See your *benefits administrator* for more information about eligibility for coverage in the retiree group.

Who is not eligible for coverage

The following individuals are not eligible for coverage under your health plan, even if they are dependents of the employee:

- divorced spouses*
- parents
- grandparents
- grandchildren**
- brothers or sisters**
- stepchildren unless both of these conditions are met: 1) the stepchild lives with the member and 2) the stepchild is a dependent of the member for federal tax purposes
- dependent child after the end of the month in which the child marries
- children age 19 or older and not eligible to be claimed on the member's income tax as a dependent (i.e., children who are self-supporting)

Members who enroll ineligible persons may be removed from the program for a period of up to three years.

* A court order to provide coverage for an ex-spouse does not make the ex-spouse eligible for coverage under this plan.
** The Department of Human Resource Management may determine when children who normally would not be eligible for coverage may qualify as eligible. Your *benefits administrator* can help you with questions about eligibility.

Other coverage rules

Survivors of state employees

If a state employee dies while in service, benefits may be available to survivors who either will immediately receive a retirement benefit from the Virginia Retirement System, or who are covered under the State Health Benefits Program at the time of the employee's death and wish to continue coverage. The deadline to enroll as a survivor is 60 days from the date of the employee's death. Health coverage may continue in the active employee group for at least 30 days after the death of a state employee.

Contact the *benefits administrator* of the agency in which the state employee worked to enroll in coverage. For additional information, consult the **Survivor Benefits Retiree Fact Sheet (#10)** on the DHRM Web site or request it from your *benefits administrator.*

Survivors of retirees and LTD participants may also be eligible for coverage. See the section entitled "When the member dies" for more information.

Extended Coverage enrollment

Extended Coverage allows former employees and covered family members to continue their State health benefits plan in certain situations at their own expense where coverage would otherwise end. Extended Coverage fulfills the same requirement that applies to non-government employees under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

The most common occurrence for choosing Extended Coverage is termination from State employment. However, other events may make you eligible for this coverage. See your *benefits administrator* for more information or see **Extended Coverage** on the DHRM Web site at **www.dhrm.state.va.us.**

Enrollment and changes

There are only certain times when you may enroll yourself and eligible dependents in a health benefits plan, or change your type of membership or plan.

When newly hired

Enroll within 31 days of the date of hire. Your health coverage is effective the first of the month after the submission of your enrollment is received. If you are hired on the first working day of the month and the form is received that day, your coverage is effective the first of that month.

Retirement

Retirees eligible for coverage in the State Retiree Health Benefits Program but not eligible for Medicare may elect to continue coverage and membership level under this plan if they enroll in the retiree group within 31 days of their retirement date. Eligible retirees who did not participate in this plan as an active employee prior to retirement may enroll in single coverage at the time of retirement if they do so within 31 days of their retirement date.

Non-Medicare eligible retiree group participants may make membership changes upon the occurrence of a qualifying mid-year event and plan and/or membership changes at open enrollment. Retiree group members may reduce membership level at any time, and the effective date will be the first day of the month after the notification is received by their *benefits administrator.* However, retirees who cancel their own coverage may not return to the program.

Long term disability

Long Term Disability (LTD) participants eligible for coverage in the State Retiree Health Benefits Program but not eligible for Medicare may elect to continue coverage and membership level under this plan if they enroll in the retiree group within 31 days of the date that their coverage as an active employee ends.

Like retirees, non-Medicare eligible LTD participants may make membership changes upon the occurrence of a qualifying mid-year event or plan and/or membership changes at open enrollment, and they may reduce their membership level at any time. However, LTD participants who cancel their own coverage outside of open enrollment and without a qualifying mid-year event, or who are terminated for non-payment of premiums while enrolled in the retiree group, will not be reinstated at any level for the duration of the LTD period.

During open enrollment

Health benefits open enrollment occurs in the spring for active employees and retirees who are not eligible for Medicare. The spring open enrollment is your opportunity to make changes in your health benefits plan and/or type of membership. The benefits and premiums associated with your open enrollment selections will be effective July 1 through June 30 of the following plan year.

Making changes outside of open enrollment

You may make membership changes during the plan year that are based on qualifying mid-year events. You must submit your change within 31 days of the event. The change will be effective the first of the month after the date the submission of an election change is received. If notice is received the first day of the month, the change is effective that day. Other exceptions are birth, adoption, placement for adoption (changes take effect the first of the month in which the event occurs) and termination of ineligible members (changes are effective the last day of the month in which the member loses eligibility).

Qualifying mid-year events

The following events permit a change outside open enrollment. You may change a benefit election when a valid change in status event occurs, but only if your change is made on account of, and corresponds with, a change in status that affects your own, your spouse's or your dependent's eligibility for coverage. You may add or remove family members during the year if you apply to do so within 31 days of the event. If you have questions about these events, contact your *benefits administrator.*

Change in your employment status:

- begins/ends full-time employment
- begins/ends leave without pay
- begins/ends family medical leave
- begins retirement

Change in your marital status:

- marriage, divorce or death of a spouse

Change in your number of eligible family members

- birth or adoption (the Department of Human Resource Management must review all pre-adoptive placements to verify eligibility)
- death of a covered child

- covered child is no longer eligible for coverage under your plan (exceed plan's age limit, marries, becomes self-supporting, etc.)
- court order to cover a child
- permanent custody of a child
- DSS order to cover a child

Changes affecting your family member(s) employment

- spouse or covered child begins employment/spouse or child ends employment
- spouse or child begins/ends leave without pay
- spouse or eligible child switched from full-time to part-time employment or vice versa

Other changes affecting your dependent(s)

- annual enrollment or change allowed under another employer's plan
- gains eligibility for Medicare or Medicaid
- loses eligibility for Medicare, Medicaid or another government-sponsored plan

Changes due to special circumstances

- permanently moves in or out of plan's service area
- special (HIPAA) enrollment due to loss of coverage
- you or your family member permanently changed residence, affecting eligibility for the State Program
- a court has required that another party cover your children

If you move in or out of your plan's service area

You may change to another plan, but not your membership, if you move in or out of your plan's service area. Submit your plan change within 31 days of the event. The change will be effective the first of the month after the submission is received.

After coverage ends

Coverage ends on the last day of the month during which eligibility ceases. Unless otherwise agreed to in writing by the Commonwealth of Virginia, Department of Human Resource Management, the *covered person's* coverage ends on the last day of the month for which full payment is made. When a *covered person* ceases to be eligible or the required premiums are not paid, the *covered person's* coverage will end.

Examples of when a *covered person's* eligibility may cease include:

- when *you* leave your job with the employer, or change from full-time to part-time employment.
- when a dependent child becomes self-supporting or marries.
- when a dependent child reaches the end of the year in which the child turns 23.
- in the case of a handicapped dependent, when the child is no longer handicapped.
- in the case of your spouse, when *you* and your spouse divorce.

There are two exceptions. If you are an *inpatient* the day your coverage ends, your hospital coverage will continue until you are discharged to the extent that services were covered prior to the end of coverage. Also, *other covered services* such as rental of medical equipment, will be provided for a limited time for a condition for which you received covered services before your coverage ended. The time will be the shorter of when you become covered under any other group coverage, or the end of the calendar year your coverage ends, or a period equal to the time you were enrolled under this plan.

When you become eligible for Medicare

You may remain enrolled under this health plan as long as *you* continue working. See your *benefits administrator* for more information. If *you* want to enroll under Medicare, *you* must make your own arrangements. Contact the nearest Social Security Office when *you* or a family member becomes eligible for Medicare (usually at age 65).

Participating retirees, LTD participants, survivors and their dependents who become eligible for Medicare, whether due to age or disability, and wish to continue participation in the State Retiree Health Benefits Program, must immediately enroll in one of the program's Medicare-coordinating plans. To ensure access to supplemental benefits, they must enroll in Medicare Parts A and B immediately upon eligibility. Failure to enroll in Parts A and B may result in coverage deficits since the program's Medicare-coordinating plans will not pay any part of a claim that would have been covered by Medicare had the participant been properly enrolled in Medicare. If it is determined that a retiree group participant is eligible for Medicare but has continued coverage in a non-Medicare plan, primary claim payments made in error may be retracted.

When the member dies

Covered family members retain coverage until the last day of the month immediately following the month the employee's death occurred. The employee's family members may elect Extended Coverage, or may also be eligible for an individual policy through Anthem.

Upon the death of a retiree or LTD participant, covered survivors are covered until the last day of the month in which the death occurs, and eligible survivors may obtain additional retiree group coverage as follows:

- Surviving family members for whom survivor retirement benefits have been provided may enroll in survivor coverage within 60 days of the retiree's/LTD participant's death, regardless of whether they had coverage prior to the retiree's/LTD participant's death (provided the retiree/LTD participant was still eligible for coverage at the time of death). Annuitant surviving spouses may continue coverage as long as the conditions outlined in the policies and procedures of the Department of Human Resource Management are met. Eligible surviving children may be covered through the end of the year in which they turn age 23 as long as they are unmarried and meet all other conditions for eligibility stated in the policies and procedures of the Department of Human Resource Management.
- Surviving family members who are enrolled in the program at the time of the retiree's/LTD participant's death may continue existing coverage in the retiree group by enrolling as survivors within 60 days of the retiree's/LTD participant's death. Non-annuitant surviving spouses may continue coverage until the end of the month in which they remarry, obtain alternate health plan coverage, or cease to meet any other applicable condition outlined in the policies and procedures of the Department of Human Resource Management. Eligible surviving children may be covered until they turn age 21 (or age 25 if a full-time student) as long as they are unmarried, do not obtain alternate health plan coverage and meet all other conditions for eligibility stated in the policies and procedures of the Department of Human Resource Management.
- Upon the death of a covered surviving spouse, dependents covered under the membership of that surviving spouse will be eligible only for Extended Coverage or conversion privileges.

Participating survivors who become eligible for Medicare must enroll in a Medicare-coordinating plan.

Continuing coverage when eligibility ends

You and your dependents (including children under their own names) may be eligible for the following:

- Extended Coverage under the Public Health Service Act; or
- individual coverage through Anthem.

Extended Coverage/Continuation of coverage (COBRA)

You and your covered family members can continue state health benefits plan membership in certain situations and at you own expense where coverage would otherwise end.

A person eligible for Extended Coverage is called a *qualified beneficiary*. This is an employee/retiree, spouse, or dependent child who was enrolled in a state health benefits plan on the day before a qualifying event. In addition, a child born to or placed for adoption with an Extended Coverage participant becomes a *qualified beneficiary* in his or her own right.

Rights of family members

Each family member enrolled in *your health plan* may determine whether or not to continue coverage. For example, if your job ends, your spouse or covered family members may elect Extended Coverage even if you decide not to enroll.

18-month Extended Coverage period

You and the family members covered by your health plan may enroll in Extended Coverage for up to 18 months, if one of the following qualifying events occurs:

- you change from full-time to part-time employment at the state
- you terminate employment (except for gross misconduct)
- you leave work voluntarily for any reason
- you go on leave without pay
- you go on approved long-term disability under the Virginia Sickness and Disability Program (VSDP)

In certain instances, this 18-month period may be extended to 29 months due to disability.

36-month Extended Coverage period for your family members

Extended Coverage can continue for 36 months if the employee's enrolled family members are no longer eligible for their health benefits plan due to one of the following qualifying events:

- family member no longer qualifies as an eligible dependent child
- employee divorces spouse resulting in loss of coverage for a spouse
- employee dies

If a spouse or covered family member is eligible for 18 months of Extended Coverage and any of the three events listed above occurs during that 18-month period, he or she may continue Extended Coverage for a total of 36 months.

Reducing or eliminating coverage when an Extended Coverage qualifying event is anticipated will not disqualify an otherwise eligible *qualified beneficiary* from receiving Extended Coverage. When a divorce occurs, once the agency *benefits administrator* receives timely notice of the qualifying event, Extended Coverage should be offered effective the first of the month after the date of the divorce, but not for any period between when the coverage was lost and the divorce became final.

When there is a divorce or a change in the status of a covered family member (such as reaching the age limit) that results in a loss of coverage, covered family members or the employee are responsible for notifying their agency *benefits administrator* within 60 days of the qualifying event. If they do not meet this notification requirement, they will forfeit all of their Extended Coverage rights associated with these events.

Special 29-month period when disability occurs

The 18-month continuation of coverage may be extended to 29 months if:

- you or one of your covered family members is found by the Social Security Administration to be disabled; *and*
- the Social Security Administration determines that the disability existed during the first 60 days of the Extended Coverage period; *and*
- the disabled person notifies the plan within 60 days of the disability determination made by the Social Security Administration and before the end of the original 18-month continuation period.

Electing coverage

The election period lasts until the later of the following:

- 60 days after group coverage ended, *or*
- 60 days after the employing agency notifies a person of his or her eligibility for Extended Coverage.

Within 14 days of receiving notice of a qualifying event, your *benefits administrator* will send you an Extended Coverage notification and a form to complete if you wish to enroll. Return the forms within 60 days from receipt if you plan to enroll in Extended Coverage.

If you decide to enroll, you have 45 days from the date you elect Extended Coverage to pay the first premium. This 45-day period begins on the date you or a family member elects Extended Coverage.

- The first premium must cover the entire period beginning with the effective date of Extended Coverage through the current month.
- Subsequent premiums will be due the first of each month of coverage until you discontinue enrollment in Extended Coverage or exhaust your time limit for coverage, whichever comes first.
- Extended Coverage will be canceled if you don't pay your premium on time. After the first premium, subsequent premiums are due the first of each month of coverage.

In most cases, Extended Coverage must begin on the day after your regular coverage has ended.

Health benefits plans available

Extended Coverage offers the same health benefits plans as those available under the Commonwealth of Virginia Health Benefits Program for active state employees.

When you first enroll in Extended Coverage

You may continue your enrollment, and that of covered family members, in the same state health benefits plan in which you were enrolled at the time of your last day of coverage in the active state employee group. You cannot add family members who were not previously enrolled with you, except in the case of the birth or adoption of a child.

Once enrolled in Extended Coverage

You may change plans and/or membership only during the Open Enrollment period. In addition, membership may be increased if you experience a qualifying mid-year event (life event) such as a marriage, birth of a child, etc.

Cost for Extended Coverage

When you enroll in Extended Coverage, you pay the total premium, plus an administrative fee.

- For the 18-month period or 36-month period, the cost for Extended Coverage is 102% of the premium.
- If you become eligible for an additional 11 months of coverage due to disability, you will pay 150% of the premium for the additional period.

Remember, the first bill will cover the period of time from your Extended Coverage effective date through the current month. After you pay the first premium, you are billed for coverage on a monthly basis.

When Extended Coverage ends

Extended Coverage ends on the last day of the month in which:

- you enroll in another group health care plan unless that program has a pre-existing condition limitation which applies to you;
- you become entitled to Medicare benefits;
- you fail to pay your monthly bill; or
- the 18-month, 29-month, or 36-month Extended Coverage period ends.

If your enrollment in Extended Coverage has been lengthened due to disability, your coverage ends the first day of the month beginning at least 30 days after the Social Security administration determines that you are no longer disabled, or at the end of the standard period of Extended Coverage due to disability.

Switching to individual coverage

Contact Anthem Personal Health Care at **800-334-7676** within 31 days of the day coverage ends to prevent a lapse in coverage. If *you* meet enrollment requirements for an individual plan and apply within 31 days, there will be no lapse in coverage. Otherwise, claims may not be paid for a period of time. To make sure *you* know what will be covered, read the individual Anthem offer carefully. It will outline:

- enrollment rules;
- the time permitted to accept the offer;
- the waiting period, if any; and
- the benefits and rates of the individual plan.

Important information about your health plan

Changes in the health plan

The Commonwealth of Virginia may amend this health plan at any time. Any amendment to the health plan will change covered services to *covered persons* on the *effective date* of the change. This applies even though *you* may have an ongoing condition at the time of the change.

Complaint and appeal process

You have access to both a complaint process and an appeal process. Should *you* have a problem or question about *your health plan,* a Member Services representative will assist *you.* Most problems and questions can be handled in this manner. *You* may also file a written complaint or appeal. Complaints typically involve issues such as dissatisfaction about *your health plan's* services, quality of care, the choice of and accessibility to *your health plan's providers* and network adequacy. Appeals typically involve a request to reverse a previous decision made by *your health plan.* Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

Complaint Process

Upon receipt, your complaint will be reviewed and investigated. *You* will receive a response within 30 calendar days of *your health plan's* receipt of your complaint. If we are unable to resolve your complaint in 30 calendar days, *you* will be notified on or before calendar day 30 that more time is required to resolve your complaint. We will then respond to *you* within an additional 30 calendar days.

Important: Written complaints or any questions concerning your medical or mental health insurance may be filed to the following addresses:

Anthem Blue Cross and Blue Shield
Attention: Member Services
P.O. Box 27401
Richmond, VA 23279

Magellan Behavioral Health
Mid-Atlantic Service Center
P.O. Box 4910
Colombia, MD 21046-4910

Appeal Process

Your health plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions *you* find unacceptable. There are two types of appeals:

- Internal appeals are requests to reconsider coverage decisions of *pre-service* or *post-service claims.* Expedited appeals are made available when the application of the time period for making pre-service or post-service appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain that cannot be adequately managed without the care or treatment. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain, when the cancer patient would be subjected to pain.
- External appeals are requests for an independent, external review of the final coverage decision made by *your health plan* through its internal appeal process. More information about this type of appeal may be found in the **External appeals** paragraph of this section.

☞ **Helpful tip:** You must file your appeal within either 15 months of the date of service or 180 days from the date you were notified of the *adverse benefit determination,* whichever is later.

How to appeal a coverage decision

To appeal a coverage decision, please send a written explanation of why *you* feel the coverage decision was incorrect. Alternatively, this information may be provided to a Member Services representative over the phone. This is your opportunity to provide any comments, documents or information that *you* feel *your health plan* should consider when reviewing your appeal. Please include with the explanation:

- the patient's name, address and telephone number;
- your identification and group number (as shown on your identification card); and
- the name of the health care professional or facility that provided the service, including the date and description of the service provided and the charge.

Important: *You* may contact Member Services with your appeal or any questions concerning your medical or mental health insurance:

Anthem Blue Cross and Blue Shield
Attention: Corporate Appeals Department
P.O. Box 27401
Richmond, VA 23279

Telephone:
804-355-8506 in Richmond
800-552-2682 from outside Richmond

Magellan Behavioral Health
Mid-Atlantic Service Center
P.O. Box 4910
Colombia, MD 21046-4910

Telephone:
800-775-5138

How your health plan will handle your appeal

In reviewing your appeal, we will take into account all the information *you* submit, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a practitioner who holds a non-restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as one who typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

We will resolve and respond in writing to your appeal within the following time frames:

- For pre-service claims, *we* will respond in writing within 30 days after receipt of the request to appeal;
- For post-service claims, *we* will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals, *we* will respond orally within one working day after receipt from the member or treating provider of the request to appeal, and will then provide written confirmation of our decision to the member and treating provider within 24 hours thereafter.

When our review of your appeal has been completed, *you* will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the plan provision(s) on which the determination is based. *You* will also be entitled to receive, upon request and at no charge, the following:

- reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- the explanation of the scientific or clinical judgement as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- the identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant's adverse decision, whether or not the advice was relied upon.

External appeals

To appeal the final coverage decision made by *your health plan* through its internal appeal process, *you* must submit to the director of the Commonwealth of Virginia, Department of Human Resource Management, in writing within 60 days of your health plan's denial, the following:

- your full name;
- your identification number;
- the date of the service;
- the name of the provider for whose services payment was denied; and
- the reason you think the claim should be paid.

You are responsible for providing the Department of Human Resource Management with all information necessary to review the denial of your claim. The Department will ask you to submit any additional information you wish to have considered in this review, and will give you the opportunity to explain, in person or by telephone, why you think the claim should be paid. Claims denied due to such things as policy or eligibility issues will be reviewed by the director. Claims denied because the treatment provided was considered not medically necessary will be referred to an independent medical review organization.

The medical review organization will examine the final denial of claims or treatment authorizations to determine whether the decision is objective, clinically valid, and comparable with established principles of health care. The decision of the medical review organization will:

- be in writing;
- contain findings of fact as to the material issues in the case and the basis for those findings; and
- be final and binding if consistent with law and policy.

If, after review, the claim remains denied, that denial is final, unless you appeal that determination within 30 days as provided under the Administrative Process Act. You may download an external appeals form at **www.dhrm.state.va.us.**

Notice in writing

A notice sent to you by Anthem or Magellan Behavioral Health is considered "given" when delivered to the Department of Human Resource Management or your *benefits administrator.* If the Commonwealth of Virginia, Anthem, or Magellan must contact you directly, a notice sent to you is considered "given" when mailed to the enrolled member at the address shown in the Commonwealth of Virginia's records. Be sure to notify the Department of Human Resource Management if your address changes.

Time limits on legal action

No legal action on a claim may be brought against Anthem, Magellan Behavioral Health or *your health plan* until after all appeal rights with respect to the claim have been exhausted. No legal action on a claim may be brought more than one year following the date that all appeal rights relating to the claim have been exhausted. This limit applies to matters relating to this health plan, to performance under this health plan, or to any statement made by an employee, officer, or director of Anthem concerning this health plan or the benefits available to a *covered person.*

Limitations of damages

In the event a *covered person* or his representative sues Anthem or Magellan Behavioral Health, or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what coverage and/or benefits, if any, exist under this health plan, the damages will be limited to the amount of the *covered person's* claim for benefits. The damages will not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. Under no circumstances will this provision be construed to limit or preclude any extra contractual damages that may be available to *you* or your representative.

Continuing rights

On occasion, the Commonwealth of Virginia, Anthem, or Magellan Behavioral Health may not insist on your strict performance of all terms of your health plan. This does not mean they give up any future rights they have under *your health plan.*

Relationship to providers

The choice of a health care *provider* is solely the *covered person's* decision. *Providers* are neither Anthem nor Magellan employees or agents. They can contract with any appropriate *provider* or *facility* to provide services to *you.* Their inclusion or exclusion of a *provider* or a covered *facility* in any network is not an indication of the *provider's* or *facility's* quality or skill. They make no guarantees about the health of any *providers.* They do not furnish covered services but only make payment for them when received by *covered persons.*

They are not liable for any act or omission of any *provider,* nor are they responsible for a *provider's* failure or refusal to render covered services to a *covered person.*

Assignment of payment

A *covered person* may not assign the right to receive payment for covered services. Prior payments to anyone, whether or not there has been an assignment of payment, will not waive or restrict Anthem or Magellan Behavioral Health's right to make future payments to a *covered person* or any other person. This provision does not apply to dentists and oral surgeons.

Once covered services are rendered by a provider, Anthem will not honor requests not to pay the claims submitted by the provider. Anthem will have no liability to any person because it rejects the request.

Member Rights and Responsibilities

Making the Most of Your Coverage

Successfulpartnerships take a strong commitment from all sides - each recognizing the rights and responsibilities of the other. Your health care is no different. It takes a strong partnership between *you,* your health care professionals, the Commonwealth of Virginia, Anthem and Magellan Behavioral Health for coverage *you* can count on.

Below is a statement of rights and responsibilities for our partnership with *you.*

Your Rights:

You have the right to receive prompt treatment and service. When it comes to your health care, *you* should always be treated promptly, with courtesy and respect and receive the medical services *you* need from health care professionals. Likewise, when *you* have questions or need help with your plan benefits, *you* should always receive prompt and courteous service from Anthem or Magellan employees.

You have the right to know about all your treatment options and to participate in all discussions and decisions about your care. We encourage the health care professionals in our networks to discuss with *you* all treatment options regardless of cost or whether your benefits will cover the care. We encourage *you* to discuss each of these treatment options with your doctor and to participate in the decision about your course of care.

You have the right to privacy. Whether by health care professionals or by Anthem or Magellan employees, *you* should always be treated with dignity, and your right to privacy should always be respected. We abide by the Commonwealth of Virginia Privacy Protection Act and have a number of other procedures in place to ensure your privacy. Any medical information about *you* that we receive, including your medical records from health care professionals or hospitals, will be kept confidential and, except as permitted by law, will not be made available to anyone without your written permission. *You* can review any personal information collected about *you* by Anthem or Magellan and corrections can be made at your request.

You have the right to health care coverage if you lose your coverage through your group plan. If *you* lose your health care coverage through your employer, *you* will still have options for health care coverage. Depending on factors such as your eligibility for other plans, your age and your state residency, *you* will be eligible for either another Blue Cross Blue Shield plan, a plan offered by another carrier or a government-sponsored program.

You have the right to voice complaints or file appeals. A Member Services representative can resolve most of your concerns if *you* are ever dissatisfied with Anthem or Magellan, or the care *you* received from a participating health care professional. But, if *you* remain dissatisfied, *you* may file a complaint or appeal a decision. This booklet outlines the steps for *you* to follow.

You have the right to information. While *you* are enrolled as a member, we will periodically send *you* information on how to use the benefits and features of your plan. *You* may also request certain information about Anthem, Magellan, or the health care professionals who contribute to your care by contacting Anthem or Magellan Member Services.

You have the right to designate an authorized representative. *You* have the right to designate an authorized representative to act on your or the patient's behalf in pursuing a claim or an appeal of an *adverse benefit determination.* This authorization may be granted for a particular event or date of service after which time the authorization approval is revoked, or may be granted for any present or future claim for health care benefits *you* may have. Designations of authorized representative status are most appropriate when being granted to a health care *provider* or an attorney that may be representing *you* in connection with a claim. Designations of authorized representative status for any present or future claims for health care benefits are more appropriately made to family members and other trusted persons whom *you* may wish to authorize to assist *you* in the future with health care claims matters. Explanation of Benefits statements will not be directed to your authorized representative, but will continue to be sent to *you* or the patient. To initiate the designation process, contact Anthem or Magellan Member Services.

Responsibilities:

You have the responsibility to work together with providers and their staff. Be a partner with your health care professionals and their treatment staff by following their advice and the care they recommend. Take the necessary steps to have your previous medical records, and any updates, transferred to your current doctor. And to the extent possible, provide your doctors with the information about your health and health habits that they may need in order to appropriately care for *you.* If *you* have questions or disagree with the treatment plan, discuss it with your provider. Make sure *you* understand the medications *you* are taking and whether *you* are scheduled for follow-up visits.

You have the responsibility to keep all diagnostic or treatment appointments as scheduled. Please consider the needs of others by being on time for appointments *you* schedule with health care professionals. And because giving patients the full attention they need does not always allow providers to stay on schedule, please be understanding if *you* have to wait before your provider can see *you.*

You have the responsibility to make your copayments (if your benefits include a copayment) at the time of your visit. Please be prepared to make your appropriate copayment when *you* receive your services.

You have the responsibility to pay monthly charges to maintain coverage (if your benefits require a monthly payment). If your monthly payment is late, the Commonwealth of Virginia, Department of Human Resource Management, has the right to suspend payment of your claims. The department will not be responsible for claims for any period for which full monthly charges have not been paid. If your monthly payment is not made within 31 days from the date due, the department may cancel your coverage. Once a full monthly payment is made, it cannot be refunded should your coverage be canceled after the first day of the month. Notice of cancellation of coverage does not relieve you from your obligation to pay the full monthly payment for any month of coverage already begun. If the entire monthly payment is not paid, coverage will be terminated and any partial amounts paid will be forfeited.

You have the responsibility to notify your benefits administrator of any changes that may affect your membership records. When a change occurs in your employment, residence, number of dependents or in coverage available through another health insurance plan (adding secondary coverage or discontinuing it, for example), it's important to notify us because the change may affect your coverage.

You have the responsibility to take an active role in managing your health. Good health management means following the advice and instructions of your doctor and making the lifestyle changes your doctor recommends.

You have the responsibility to know what is considered emergency care. Be familiar with when to use the *emergency* room for care and when to seek care from your doctor. This booklet includes more information on when and how to use emergency room services.

HIPAA Privacy Practices

Disclosure of Protected Health Information to the Employer

(1) Definitions. Whenever used in this Article, the following terms shall have the respective meanings set forth below.

(a) Plan - means the "State Health Benefits Programs."
(b) Employer - means the "Commonwealth of Virginia."
(c) Plan Administration Functions - means administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.
(d) Health Information - means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined by the Health Insurance Portability and Accountability Act of 1996, subsequently referred to as HIPAA, in 45 CFR Section 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined by HIPAA in 45 CFR Section 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for

the provision of health care to an individual.

(e) Individually Identifiable Health Information - means Health Information, including demographic information, collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.

(f) Summary Health Information - means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed: (1) names; (2) geographic information more specific than state; (3) all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older); (4) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers; (5) facial photographs or biometric identifiers (e.g., finger prints); and (6) any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.

(g) Protected Health Information ("PHI") means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

(2) The Plan, and the agents acting on its behalf, may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

(3) The Plan, and the agents acting on its behalf, will disclose PHI to the Employer only in accordance with HIPAA in 45 CFR Section 164.504(f) and the provisions of this Section.

(4) The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose PHI to the Employer and acknowledges receipt of written certification from the Employer that the Plan has been so amended. Additionally, the Employer agrees:

(a) not to use or further disclose PHI other than as permitted in Section (4) or as required by law;

(b) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;

(c) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;

(d) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in Section (4);

(e) to make PHI available to individuals in accordance with HIPAA in 45 CFR Section 164.524;

(f) to make PHI available for individuals' amendment and incorporate any amendments in accordance with HIPAA in 45 CFR Section 164.526;

(g) to make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA in 45 CFR Section 164.528;

(h) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan and its agents available to the Department of Health and Human Services upon request; and

(i) if feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible.

(j) to ensure that adequate separation between the Plan and the Employer, as required by HIPAA in 45 CFR Section 164.504(f), is established and maintained.

(5) The Plan will disclose PHI only to the following employees or classes of employees:

- Director, Department of Human Resource Management
- Director of Finance, Department of Human Resource Management
- Staff Members, Office of Health Benefits

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

(6) Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Section by individuals described in Section (5) shall be considered "failure to comply with established written policy" (a Group II offense) and must be addressed under the Commonwealth of Virginia's Policy 1.60, Standards of Conduct Policy. The appropriate level of disciplinary action will be determined on a case-by-case basis by the agency head or designee, with sanctions up to or including termination depending on the severity of the offense, consistent with Policy 1.60.

(7) A health insurance issuer, HMO or third party administrator providing services to the Plan is not permitted to disclose PHI to the Employer except as would be permitted by the Plan in this Article and only if a notice is maintained and provided as required by HIPAA in 45 CFR Section 164.520.

Definitions

Activities of daily living
means walking, eating, drinking, dressing, toileting, transferring (e.g. wheelchair to bed), and bathing.

Acute care
for mental health and substance abuse treatment is inpatient care in which the patient is in a facility 24 hours a day under the care and direction of an attending physician.

Adverse benefit determination
is any denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by the health plan.

Allowable charge
means the amount on which deductible (if any), copayment, and coinsurance amounts for eligible services are calculated.

Baby Benefits
is a program designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery.

Benefits administrator
is the person appointed by your employer to assist *you* with *your health plan.* Your *benefits administrator* may also provide *you* information about your benefits. If there is a conflict between what your *benefits administrator* tells *you* and *your health plan* itself, your benefits will, to the extent permitted by law, be determined on the basis of the language in this booklet. Anthem may send notices intended for you to the *benefits administrator. You* may be provided with brochures, employee communications, or other material that describes the benefits available under *your health plan.* In the event of conflict between this type of information and *your health plan,* your benefits will be determined on the basis of the language in this booklet.

Coinsurance
is the percentage of the allowable charge you pay for some covered services.

Copayment
is the fixed dollar amount you pay for some covered services.

Covered persons
are you and enrolled eligible dependents.

Deductible
is a fixed dollar amount of covered services you pay in a calendar year before your health plan will pay for certain remaining covered services during that calendar year.

Durable medical equipment
is used for a medical purpose, can withstand repeated use, and is appropriate for use in your home for daily living purposes.

Effective date
is the date coverage begins for you and/or your dependents enrolled under the health plan.

Emergency
is the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity. This includes severe pain that without immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in:
- serious jeopardy to the mental or physical health of the individual;
- danger of serious impairment of the individual's body functions;
- serious dysfunction of any of the individual's bodily organs; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental/investigative
means any service or supply that is judged to be experimental or investigative at Anthem's sole discretion. Refer to **Exhibit B** for more information.

Extended Coverage (COBRA) beneficiary
is you or a covered dependent who elects to continue group coverage under Extended Coverage.

Facilities are:
- dialysis centers
- home health care agencies
- hospice providers
- hospitals
- skilled nursing facilities

First-tier drug
is a low cost drug, typically a generic drug.

High dose
means a dose of chemotherapy or radiation so high that it predictably requires stem cell rescue.

Home care services
are services rendered in the home setting. Home care includes services such as skilled nursing visits and physical, speech, and occupational therapy for patients confined to their homes. This also means home infusion services; which is therapy including such services as the intravenous and parenteral administration of medication to patients as well as enteral and parenteral nutrition. Home infusion therapy does not require that the patient is confined to his/her home.

Inpatient
means when you are a bed patient in the hospital.

Inpatient facilities
are settings where patients can spend the night, including hospitals, skilled nursing facilities, and partial day programs.

Levels of care
for mental health and substance abuse treatment refers to the different types of treatment settings available to patients such as inpatient, partial, intensive outpatient, and outpatient care.

Maintenance medications
are those you take routinely to treat or control a chronic illness such as heart disease, high blood pressure, or diabetes.

Medically necessary
to be considered medically necessary, a service must:
- be required to identify or treat an illness, injury, or pregnancy-related condition;
- be consistent with the symptoms or diagnosis and treatment of your condition;
- be in accordance with standards of generally accepted medical practice; and
- be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the provider.

Other covered services
are subject to the calendar year deductible and include the following services:
- ambulance travel;
- dental accident services;
- diabetic supplies and equipment;
- home private duty nursing services;
- medical equipment, appliances, supplies and medications; and
- vision correction after surgery or accident.

Outpatient
is when you receive care in a hospital outpatient department, emergency room, professional provider's office, or your home.

Outpatient mental health services
are for the diagnosis and treatment of psychiatric conditions and include individual psychotherapy, group psychotherapy, and psychological testing.

Outpatient treatment
under your mental health and substance abuse treatment benefits is for the diagnosis and treatment of psychiatric conditions and includes individual psychotherapy, group psychotherapy, and psychological testing.

Partial day service
for mental health and substance abuse treatment is intensive treatment in a medically supervised setting with the opportunity for the patient to return home or to another residential setting at night.

Post-service claims
are all claims other than pre-service claims and urgent care claims. Post-service claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where you request authorization in advance.

Preauthorization
for mental health and substance abuse treatment is the process of referring you to an appropriate provider and reviewing your treatment plan against medical necessity criteria. The process also includes referring *you* to an appropriate provider for your condition.

Prescription drugs
are medicines, including insulin, that require a prescription order from your doctor.

Pre-service claims
are claims for a service where the terms of the health plan require the member to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If you call to receive authorization for a service when authorization in advance is not required, that claim will be considered a post-service claim.

Primary care physician (PCP)
is a general or family practitioner, internist or pediatrician.

Providers (who may give care under your health plan):
- audiologists
- certified nurse midwives
- chiropractors
- chiropodists
- clinical social workers, psychologists, clinical nurse specialists in psychiatric mental health, professional counselors, marriage and family therapists
- dentists
- doctors of medicine (MD), including osteopaths and other specialists
- independent clinical reference laboratories
- opticians
- optometrists
- podiatrists
- registered physical therapists
- speech pathologists

Qualified beneficiary
is an employee/retiree, spouse or dependent child who was enrolled in the plan on the day before the qualifying event. In addition, a child born or placed for adoption with an Extended Coverage member becomes a qualified beneficiary in his or her own right.

Qualifying event
is an event that allows you or covered persons enrolled with you to select Extended Coverage.

Second-tier drug
is a moderate cost drug, typically a multi-source brand name drug. A multi-source brand name drug is a brand name drug which has a generic equivalent.

Setting
is the place where you receive treatment. It could be your home, your provider's office, a hospital outpatient department, a skilled nursing home, hospital inpatient room, or a partial day program.

Skilled nursing facility
is a facility licensed by the state in which it operates to provide medically skilled services to inpatients.

Specialty care providers
are any covered providers other than those defined as primary care physicians.

Stay
is the period from the admission to the date of discharge from a facility. All hospital stays less than 90 days apart are considered the same stay, and a new hospital inpatient copayment will not apply.

Third-tier drug
is a higher cost drug, typically a single source brand name drug. A single source brand name drug is a brand name drug which does not have a generic equivalent.

Visit
a period during which a covered person meets with a provider to receive covered services.

You
the enrolled member.

Your health plan
the COVA Care plan.

Exhibit A

Specified conditions for allogeneic bone marrow transplants:

- aplastic anemia;
- acute leukemia;
- Hodgkin's lymphoma;
- non-Hodgkin's lymphoma, except small cell lymphocytic lymphoma;
- severe combined immunodeficiency;
- Wiskott-Aldrich syndrome;
- infantile malignant osteopetrosis;
- chronic myelogenous leukemia;
- neuroblastoma;
- primitive neuroectodermal tumor;
- thalassemia major;
- lysosomal storage disorders;
- myelodysplastic syndrome;
- severe myeloproliferative diseases;
- sickle cell anemia in children or young adults with severe symptoms that increase the risk of stroke or end organ damage, or who have a history of prior stroke and who have an HLA-identical, related donor;
- mucopolysaccharidoses (e.g., Hunter's, Hurler's Sanflippo, Maroteaux-Lamy variants) in patients who are neurologically intact;
- mucolipidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact;
- Kostmann's Syndrome;
- leukocyte adhesion deficiencies;
- x-linked lymphoproliferative syndrome; and
- megakaryocytic thrombocytopenia.

Exhibit A-1

Specified conditions for autologous bone marrow transplants:

- Hodgkin's lymphoma;
- non-Hodgkin's lymphoma;
- primary amyloidosis;
- neuroblastoma;
- primitive neuroectodermal tumor;
- multiple myeloma;
- acute lymphocytic or non-lymphocytic leukemia;
- germ cell tumors; and
- breast cancer, but only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of experimental/investigative services.

Exhibit B

Experimental/investigative criteria

Experimental/investigative means any service or supply that is judged to be experimental or investigative at *Anthem's* sole discretion. Services which do not meet each of the following criteria will be excluded from coverage as *experimental/investigative:*

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.

   a) This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:
   - the following three standard reference compendia defined below:
     1) the U.S. Pharmacopoeia Dispensing Information
     2) the American Medical Association Drug Evaluations
     3) the American Hospital Formulary Service Drug Information
   - in substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or

   b) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

   Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

2. There must be enough information in the peer-reviewed medical and scientific literature to let us judge the safety and efficacy.

3. The available scientific evidence must show a good effect on health outcomes outside a research *setting.*

4. The service or supply must be as safe and effective outside a research *setting* as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered *experimental/investigative.*

Clinical trial costs

Clinical trial cost means patient costs incurred during participation in a clinical trial when such a trial is conducted to study the effectiveness of a particular treatment of cancer where all of the following circumstances exist:

1) The treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial;
2) Treatment provided by a clinical trial is approved by:
   - The National Cancer Institute (NCI);
   - An NCI cooperative group or an NCI center;
   - The U.S. Food and Drug Administration in the form of an investigational new drug application;
   - The Federal Department of Veterans Affairs; or
   - An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI;
3) With respect to the treatment provided by a clinical trial:
   - There is no clearly superior, non-investigational treatment alternative;
   - The available clinical or preclinical data provides a reasonable exception that the treatment will be at least as effective as the non-investigational alternative; and
   - The *covered person* and the physician or health care *provider* who provides the services to the *covered person* conclude that the *covered person's* participation in the clinical trial would be appropriate; and
4) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise.

"Patient cost" under this paragraph means the cost of a *medically necessary* health care service that is incurred as a result of the treatment being provided to the *covered person* for purposes of a clinical trial. "Patient cost" does not include (i) the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

Index

Special Features and Programs

Your health plan covers a wide range of benefits to help you stay as healthy as possible. Having a healthy lifestyle and knowing how to make smart lifestyle choices can often improve health. For these reasons, your health plan provides you access to the following programs.

CommonHealth Wellness Program

The CommonHealth wellness program is offered to state employees through participating state agencies. The program is designed to make a positive difference in the health of the employee by integrating health awareness into the workplace. CommonHealth features a variety of medical screenings including cholesterol and blood pressure; fitness classes and challenges; health education programs and other activities. For more information, visit the CommonHealth Web site at **www.chp-online.com/commonhealth.**

Better Prepared℠

If you or a family member are living with asthma, diabetes, coronary artery disease or congestive heart failure, you know the impact that it has on your life. This confidential disease management program will provide the tools and support needed to minimize your condition's effects, improve your health and help you feel better.

Better Prepared is a voluntary program and information is held in strict confidence. To register in this program, call **800-445-7922.** A dedicated nurse will be available to answer your questions, help you coordinate your benefits, and provide support to help you follow your doctor's plan of treatment.

Anthem Healthy Complements℠

An alternative health care program

Although these services are not part of the health and wellness benefits under your health plan, they are provided to you as a plan participant. Discount services are available through networks administered by other companies, many of which are national leaders in their fields. The discount services listed below are not covered as benefits under your health plan and can be discontinued at any time.

The Anthem Healthy Complements program links you to a network of acupuncturists, massage therapists and fitness clubs. Typically, you will receive a 25% discount from these providers and preferred pricing from fitness clubs.

Discounts on chiropractic services are also available once you have met your health plan's calendar year limit for spinal manipulations. For more information on the calendar year limit for these services, see the spinal manipulations benefit in the **Summary of benefits** section of this member booklet.

The Anthem Healthy Complements program, administered through American Specialty Health Networks, is easy to use - no claim forms, no visit limits, no referrals. To take advantage of the discounts provided by this program:

- Identify the participating acupuncturists, massage therapists, fitness clubs and chiropractors you want to see by using the online provider directory accessed through our Web site **www.anthem.com** or by calling **877-327-2746.**
- Schedule an appointment directly with the provider.
- Present your Anthem ID card and pay the provider directly.

Plus, you can receive discounts when you purchase health-related products such as vitamins, minerals, herbal supplements, health and wellness books and videos. There is no additional cost to you for shipping. To obtain information on the complete product line available to you at a discount, you can:

- visit our Web site at **www.anthem.com;** or
- request a catalog by calling **877-327-2746.**

When ordering, make sure you identify yourself as an Anthem member to receive your discount and free shipping.

If you have questions or would like a complete information package on the Anthem Healthy Complements program, call **877-327-2746.**

Optional Benefits

Your health plan offers three optional benefits plans that can be purchased to supplement benefits included with the COVA Care Basic plan. *You* will be required to contribute toward the cost through additional payroll deductions in order to receive optional benefits. Each optional benefits plan is available separately, or *you* may elect to combine the Out-of-network option with either the Expanded dental option or the Vision, hearing and expanded dental option.

Out-of-network option

Under the COVA Care Basic plan, except in an emergency, *you* do not have coverage for the services of *facilities* and *providers* outside of the Anthem, BlueCard, or Magellan Behavioral Health networks. Selecting the Out-of-network option adds coverage for these *facilities* and *providers.*

The out-of-network benefit will always be the in-network benefit less a 25% reduction in the amount paid by *your health plan.* You will also be responsible for any deductible or copayment that applies.

For example, *if you have the out-of-network option and are admitted to a non-network hospital,* you will pay your inpatient facility copayment and Anthem will pay 75% of the allowable charge. You also pay any amount the non-network provider charges over the allowable charge.

In addition to adding coverage for *facilities* and *providers* outside your networks, the out-of-network option allows the accumulation of *deductible, copayment* and *coinsurance* amounts for these *facilities* and *providers* towards your out-of-pocket expense limits. However, the 25% reduction in the amount paid by *your health plan* will not count toward your out-of-pocket expense limits. Please see the **Claims and payments** section for a complete description of the out-of-pocket expense limit accumulations.

Expanded dental option

The COVA Care Basic plan automatically includes coverage for diagnostic and preventive, and primary dental services. The Expanded dental option adds coverage for the following prosthetic, complex restorative, and orthodontic services:

Prosthetic and complex restorative services

If preventive services fail to save a tooth, the Expanded dental option adds benefits for prosthetic and complex restorative services. These benefits include:

- inlays;
- onlays;
- crowns, crown repair, and post and core build-ups for crowns;
- labial veneers involving the incisal edge of anterior teeth, porcelain laminate (Laboratory processed);
- dental implants;
- dentures (full and partial), and denture adjustments and relining; and

- fixed bridges and repair.

Anthem must approve permanent crowns for *covered persons* under age 16 in advance. Replacement of prosthetic appliances, dentures, crowns, crown buildups, post and core to support crowns, onlays and bridges are limited to once every five-year period. There is one exception: Replacement of a bridge will be provided prior to the end of the five-year period if one or more abutment teeth are extracted.

When the Expanded dental option is selected, prosthetic and complex restorative services are covered at 50% coinsurance. The annual maximum that *your health plan* covers is increased from $1200 under the basic plan to $1500 per calendar year.

Orthodontic services

The Expanded dental option also provides coverage for orthodontic services. Benefits are available if the problem is a handicapping malocclusion. That means it prevents normal chewing or eating. Your coverage includes:

- orthodontic appliances (installing only, no replacement or repair);
- services needed to diagnose the problem, including x-rays and study models;
- tooth guidance and harmful habit appliances;
- interceptive treatment;
- surgical access of unerupted teeth when performed for orthodontic purposes; and
- orthodontic evaluations when no treatment is initiated.

Your health plan includes coverage at 50% coinsurance for orthodontic services and pays up to $1200 per lifetime for orthodontic benefits. There is a 12-month waiting period for orthodontic services. Credit toward this waiting period will be given if you had orthodontic benefits under previous coverage, and there is no more than a 63 day lapse between your previous coverage and this coverage. In addition, orthodontic benefits paid under the previous coverage will count against the $1200 lifetime limit.

Vision, hearing and expanded dental option

The Vision, hearing and expanded dental option adds routine vision and hearing services, and all the benefits of the expanded dental option described earlier in this section.

Vision services

The Vision, hearing and expanded dental option adds coverage for certain vision care services to identify and correct refractive error. Benefits are provided up to a maximum payment established for each covered service. These services may be obtained from an optometrist, optician, or ophthalmologist. The following services are covered:

- an eye examination once every 24 months (you pay $35 copayment);
- one set of frames every 24 months ($75 benefit maximum);

- one pair of single ($50 benefit maximum), bifocal ($75 benefit maximum), or trifocal ($100 benefit maximum) eyeglass lenses every 24 months; or contact lenses of any type ($100 benefit maximum), instead of eyeglass lenses, every 24 months.

Hearing services

The Vision, hearing and expanded dental option adds coverage for certain hearing care services to identify and treat hearing loss. Benefits are provided up to a maximum payment established for each covered service. The examination may be obtained from an audiologist or doctor of medicine.

The following services are covered:

- an examination once every 48 months (you pay $35 copayment); and
- hearing aid(s) and other related hearing aid services such as selection and fitting every 48 months ($1,200 benefit maximum).

Expanded dental

The COVA Care basic plan includes coverage for routine diagnostic and preventive, and primary dental services. The Expanded dental option described earlier in this section adds benefits for prosthetic and complex restorative services and orthodontic services.

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Virginia Department of
HUMAN RESOURCE
MANAGEMENT

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